



## Claim Form Health Insurance

**Do you want to submit a claim? Then first read the information below.**

### **Have you made an appointment?**

Do so in advance to submit your claim and to receive the processed invoices and proofs of payment.

### **Claims are personal**

Each family member needs to submit their own claim in accordance with the points below.

### **Payment of health care bills**

The Health Insurance Office always pays the invoice amount to you. You always pay the bill of the doctor, health care institution etc. yourself. If you submit the invoices of the paid bills to the Health Insurance Office as soon as possible, we will make sure that you in turn receive notification of this submission as soon as possible.

### **Authorization in advance Article 10 paragraph 4**

In a number of cases, you will need prior authorization. For example, for Article 10 paragraph 4. When you claim medical expenses as a result of an authorization for Article 10 paragraph 4, you must first pay the bills of the doctor or health care institution yourself as stated in the conditions for authorization based on Article 10 paragraph 4. In these cases, you must submit the proofs of payment together with your claim.

### **Letter of Guarantee**

Did you receive a letter of guarantee? Then enclose it with your claim.

### **Medical assistance after an accident**

If your medical bill relates to an accident for which a third party may be liable, please indicate this on the claim form and the relevant invoice. We will then ask you for further information about the accident in order to determine whether we can hold third parties liable. This has no consequences for your compensation; you will receive what you are entitled to.

### **Claim period**

Submit the claim to Zorg en Jeugd Caribisch Nederland (ZJCN) as soon as possible. Claims older than 12 months will not be processed.

### **Are your name, address, telephone number and bank details correct?**

This is important for your payment and possible contact with ZJCN about your claim.

### **Statement of agreement**

By signing the claim form you state that your claim meets the conditions below. If your claim does not meet these conditions, we cannot accept your claim.

### **Which criteria does my claim have to meet?**

- You must have been registered with ZJCN at the time that the costs were incurred.
- You must have contacted ZJCN immediately in the event of illness, accident or admission abroad
- You must describe your claim. This is mandatory.
- You must sign the claim form.
- You must submit the referral letter from the general practitioner and/or the medical statement from the attending doctor.
- You must submit the original doctor/hospital/first-aid bills and, in the case of Article 10 paragraph 4, the original proofs of payment of these doctor/hospital/first-aid bills.

**Incomplete claims will not be processed.**

# Claim Form Health Insurance

**Serial number**

Please fill in in BLOKLETTERS.

## 1 Applicant, my details are:

First name: (in full)

\_\_\_\_\_

Surname (*maiden name in case of marriage*)

\_\_\_\_\_

ID number (sedula)

\_\_\_\_\_

Date of birth (mm/dd/yyyy)

\_\_\_\_\_

Address

\_\_\_\_\_

Place

\_\_\_\_\_

E-mail address

\_\_\_\_\_

Daytime telephone number

\_\_\_\_\_

Bank account number

\_\_\_\_\_

Name and place Bank

\_\_\_\_\_

In name of

\_\_\_\_\_

## 2 Bills to be submitted

Would you like to include the original invoices with any references when submitting your claim? The Health Insurance Office will stamp them and immediately scan them and return them to you. Please complete this form in full.

**Incomplete claims will not be processed.**

Invoice from (doctor, health-care institution, etc.)	Invoice date (mm/dd/yyyy)	Currency	Total invoice amount	Description received care
1	_____			
2	_____			
3	_____			
4	_____			
5	_____			
6	_____			
7	_____			
8	_____			
9	_____			
10	_____			

1 US\$ = 1,78 NAF

Number of attachments \_\_\_\_\_

Total in US\$: \_\_\_\_\_



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## 4 Signature

I certify that this form has been completed accurately, completely and truthfully.

Place

Date (mm/dd/yyyy)

\_\_\_\_\_

Number of attachments

\_\_\_\_\_

Signature

\_\_\_\_\_

## To be completed by the Health Insurance Office:

\_\_\_\_\_

Received on: (mm/dd/yyyy)

\_\_\_\_\_

Received by:

\_\_\_\_\_