Groupama Sigorta

Call Center | 0850 250 50 50

www.groupama.com.tr

HEALTH INSURANCE CLAIM FORM

THIS SECTION IS TO BE COMPLETED BY THE INSURED.

Insured's Name and Last Name : .....

Date of Birth : .....

Turkish ID Number : .....

Client & Policy Nos. : .....

Name of the Group : .....

Phone Number : .....

Name and Last Name of Holder of the Account for Indemnity Payment

.....

Bank : .....

Branch Office : .....

Branch Office Code : .....

Account No : .....

IBAN No : .....

Healthcare Institution/ Name of Doctor/ Description of Procedure	Date of Invoice	No of Invoice	Amount of Invoice
TOTAL			

THIS SECTION IS TO BE COMPLETED BY THE ATTENDING PHYSICIAN.

Healthcare Institution where service received		Name and Last Name of the Attending Physician	
Complaint(s) of the Insured			
Date when first symptoms appeared and findings of examination and anamnesis		Specialty	
Did the insured apply to a physician, received any test and treatment for the same complaint/disease before? (Name of the healthcare institution/physician applied)		Phone no	
		Stamp and Signature	
History / Drugs Currently Used			
Required Tests			
Preliminary or Conclusive Diagnosis			
If pregnancy, date of inception and date of last period			
Carried out or recommended treatment		Date	

If Groupama Sigorta A.Ş. determines after having paid indemnity to me that my complaint for which I received medical treatment and/or any expenses incurred for diagnosis and treatment of my complaint are excluded from the coverage as per the general and special conditions of the policy as well as the limits of coverage or that I have acted contrary to the rules of good faith, I agree, declare and undertake to refund the indemnity, together with the interest accrued thereon at the rate of rediscount interest rate, to Groupama Sigorta A.Ş. in cash lump sum upon their first demand, to compensate any loss incurred by Groupama Sigorta A.Ş. because of this, and that payment of indemnity in respect of this complaint will not constitute a precedent for payment of indemnity claimed by me for the same complaint in the future. I hereby give consent to Groupama Sigorta A.Ş. to obtain information and documents about health condition of me and/or my family members who are insured under the respective policy from any healthcare institution, physician and third person and agree to provide any additional information about the same when needed.

In order to receive faster service, please attach to this form originals of Invoices/Cash Register Slips/Bills, originals of drug/vaccine prescriptions and tags/barcodes, test requests and test results (photocopy acceptable), itemized invoices of hospitalization or surgical expenses (photocopy acceptable), surgery report (photocopy acceptable), hospital discharge report (photocopy acceptable) and other required documents. Please remember that you are obliged to answer all questions asked to you.

Insured's Signature **Date**