

Skandia Private Health Care



Claim Form

Skandia Operation Skandia Health Care Skandia Health Care Plus

		Policy number
Name and address		E-mail address
Surname and forename (Please write clearly, preferably in block letters)		Social security number
Street address		Workplace phone (with area code)
Postcode and city/town		Home phone (with area code)

Description of illness

Date of onset of illness
Name of illness / nature of symptoms
When did you visit a physician? Date
Name of physician and hospital
Referral (In Skandia Health Care) <input type="checkbox"/> No <input type="checkbox"/> Yes
Have you been referred to a specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes
Who referred you?
Have you previously had a similar illness/symptoms? <input type="checkbox"/> No <input type="checkbox"/> Yes
When? / What kind of illness/symptoms?
Name of attending physician and hospital

Description of accident

Date of accident	The accident occurred		
	<input type="checkbox"/> At work	<input type="checkbox"/> On the way to/from work	<input type="checkbox"/> During leisure time
Description of how the accident occurred and nature of injury.			
When did you visit a physician? Date			
Name of physician and hospital			
Referral (In Skandia Health Care) <input type="checkbox"/> No <input type="checkbox"/> Yes			
Have you been referred to a specialist? <input type="checkbox"/> No <input type="checkbox"/> Yes			
Who referred you?			
Have you previously had a defect or injury in the same part of the body? <input type="checkbox"/> No <input type="checkbox"/> Yes			
When and What?			
Name of attending physician and hospital			

Are you fully recovered / free of symptoms? No Yes

Claim form for expenses incurred: please turn over.

CLAIM FOR REIMBURSEMENT AND AUTHORISATION To KELA / workplace fund for medical expenses

Please fill in this form if you have not claimed reimbursement for medical expenses from KELA in accordance with the Sickness Insurance Act (Sairausvakuutuslaki). The application and related receipts must be submitted to Skandia within six months of the original expenditure.

Name of claimant (insured)		Social security number
Street address		Postcode
		City/town
Has the insured received any other reimbursement for the expenditure concerned? <input type="checkbox"/> No <input type="checkbox"/> Yes. From where? How much?		Was the claimant staying at a public hospital / other medical facility when the expenses were incurred? <input type="checkbox"/> No <input type="checkbox"/> Yes. Where?
Were the expenses caused by a traffic accident, workplace accident or diagnosed occupational disease? <input type="checkbox"/> No <input type="checkbox"/> Yes. Name of insurance company		
I hereby certify that the information provided is accurate and authorise Skandia to obtain the reimbursement granted to me.		
Place and date		Signature of claimant or his/her representative and name in block letters

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Claim Form

Accident occurred while travelling:

Start date of journey	Planned end date	Has SOS International been contacted? <input type="checkbox"/> No <input type="checkbox"/> Yes
Do you have a health, accident, travel or home insurance policy? <input type="checkbox"/> No <input type="checkbox"/> Yes	Name of company	Policy number

Other information

Itemisation of self-paid medical expenses

Note: Please enclose original receipts

Examination and treatment costs

	Amount €	Attachments

Prescribed medication

	Amount €	Attachments

Use of own car and other travel costs

Date	Route	Kilometres covered or amount	Attachments
		In total:	

Method of payment

Recipient	Bank account number
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Signature

I hereby certify that the information provided is accurate and complete. I authorise any physician, hospital or other medical facility to submit any medical information for the purpose of processing the claim to the insurance company.

Date	Signature	Name in block letters