

**CLAIM FOR INDEMNITY
TRAVEL ILLNESS OR ACCIDENT**



- Company's personal accident insurance
 Business travel insurance
 Secondment insurance
 International secondment insurance

**FOR INSTRUCTIONS ON FILLING
IN THIS FORM, SEE OVERLEAF**

Insurance card number

POLICY-HOLDER (= employer)	Name		
	Postal address	Postal code	Phone
INJURED/ SICK PERSON	Name		Social security No (date of birth)
	Postal address	Postal code	Phone
PAYMENT OF INDEMNITY	Recipient of compensation		Bank; bank's address if outside Finland
	Address		
	Account No	SWIFT code or national code	
POWER OF ATTORNEY	Do you fall within the scope of the Finnish sickness insurance system? <input type="checkbox"/> Yes <input type="checkbox"/> No		
	I hereby authorise If P & C Insurance Company Ltd. to apply for, draw and sign for compensation payable for medical expenses under the Finnish Sickness Insurance Act, up to the amount of medical expenses paid by If P & C Insurance Company Ltd. This power of attorney is valid until further notice.		
	Place and date	Signature of the assignor (guardian)	
CIRCUMSTANCES OF EVENT INSURED	<input type="checkbox"/> accident <input type="checkbox"/> illness <input type="checkbox"/> Health care <input type="checkbox"/> Employment accident		
	Date of accident or the first signs of illness	Time	Location
INFORMATION ON ILLNESS OR ACCIDENT DURING A JOURNEY	Describe in detail the accident and what the injured person was doing when it happened. When illness is concerned, give an accurate report on how the signs of the illness appeared and on the costs of health care.		
	Names and addresses of other people involved in the accident		
	Names and addresses of eye witnesses		
	Influence of intoxicants or drugs? <input type="checkbox"/> Yes <input type="checkbox"/> No	Has police investigation been held? <input type="checkbox"/> Yes <input type="checkbox"/> No	Location and time
TRAVEL INFORMATION	Journey began	Intended return	When did you return?
	<input type="checkbox"/> Business journey paid by the employer <input type="checkbox"/> Leisure journey		
INFORMATION ON THE BUSINESS ASSIGNMENT JOURNEY	Employment relationship of the injured/sick person to the policyholder	Length of assignment	
		<input type="checkbox"/> The injured/sick person is a family member <input type="checkbox"/> accompanying the insured	
TREATMENT OF INJURY OR ILLNESS	When did you consult a doctor?	Name and address of doctor	
	Were you treated in hospital? <input type="checkbox"/> yes <input type="checkbox"/> no	Name and address of hospital	

INSTRUCTIONS ON FILLING IN THIS FORM

- Fill in a separate form for each family member and insured event
- Answer all questions
- Write the name of the recipient of compensation clearly
- If your bank is not in Finland, give the SWIFT code of the bank (consult your bank for this) or a national code, for example, BLZ in Germany, SC in UK
- Give the date on which the accident or illness occurred
- Give the reason for consulting a physician in section "Clarification of event insured"

ATTACH TO THE CLAIM

- medical certificate. In minor cases a diagnosis in the doctor's fee receipt is a minimum requirement
- original documents. For medication, both the prescription and the pharmacy receipt are required

PREVIOUS ILLNESSES	Have you previously suffered from a similar illness or from symptoms related to this illness <input type="checkbox"/> Yes <input type="checkbox"/> No when?		
	Name and address of the doctor who gave treatment		
EXPENSES FOR MEDICAL TREATMENT	ALL RECEIPTS SHALL BE ENCLOSED IN THE ORIGINAL		
	AMOUNT	ENCLOSURE	CURRENCY
	DOCTOR'S FEE		
	HOSPITAL CHARGES		
	TRAVEL EXPENSES		
	MEDICINES		
	OTHER MEDICAL EXPENSES		
EXPENSES ARISING FROM INTERRUPTED OR CANCELLED JOURNEY	ADDITIONAL TRAVEL EXPENSES		
	ADDITIONAL ACCOMMODATION EXPENSES		
	OTHER EXPENSES		
OTHER INSURANCES	Are you insured against this loss with another insurance company <input type="checkbox"/> Yes <input type="checkbox"/> No company		
ADDITIONAL INFORMATION	Additional information is given by	E-mail	
	Phone during office hours	Telefax	
	The claim for indemnity will be sent to the Policyholder/employer, who will forward it to If P & C Insurance Company Ltd. If the form contains information which you do not want the Policyholder/employer to know, you can send it directly to: If P & C Insurance Company Ltd., Corporate Travel Insurance, Vattuniemenkuja 8 A, FIN-00025 IF, FINLAND		
SIGNATURE OF THE INJURED	I confirm that the above information is correct. I allow that If P & C Insurance Company Ltd. will obtain the information needed to settle this claim from those doctors, hospitals, The Social Insurance Institution and other institutes or persons who have information concerning my health.		
	Place and date	Signature of the claimant	
SIGNATURE OF THE EMPLOYER	We confirm that the injured/sick person was when the accident/illness occurred employed by the above mentioned policyholder or is an accompanying family member of the employee and is covered by the insurance		
	Place and date	Signature of an authorized officer of the employer	