



Name policyholder: \_\_\_\_\_

Street name: \_\_\_\_\_

Postcode: \_\_\_\_\_

Place of residence: \_\_\_\_\_

Telephone number ( during the day): \_\_\_\_\_

E-mail address: \_\_\_\_\_

Policy number: \_\_\_\_\_

**Explanation and tips for a quick settlement.**

- 1 Send the fully completed and signed form together with the original bills to **OZF, Postbus 94, 7550 AB Hengelo**
- 2 All bills have to be provided with a policynumber of the treated policyholder
- 3 Make a copy of this form and of the original bills for your own administration
- 4 In case of an accident with an opposite party, this should be mentioned on this form
- 5 Send us your bills on a regular basis
- 6 This form can be downloaded of [www.ozf.nl](http://www.ozf.nl)

Initials, date of birth and policy number of the treated policyholder.	Careprovider ( for example: general practitioner, dentist, pharmacist, specialist)	Explanation of treatment carried out	Number of enclosed bills
<b>Number of enclosed bills</b> _____		<b>Total declared amount</b> _____	

In case of an accident, where the opposite party can be held responsible for?  Yes  No

## Specification of medical care

Country or location of treatment and hospitalisation \_\_\_\_\_

Residence period abroad \_\_\_\_\_

Date of departure \_\_\_\_\_

Date of return \_\_\_\_\_

Is there a case of hospitalisation

No  Yes

Has the hospitalisation been reported to Emergency center Eurocross

No  Yes,

The medical help could have been postponed till return in the Netherlands

No  Yes

Where there already disturbances in Holland,  
for which treatment took place abroad

No  Yes

Have the costs been made because of occupationtasks

No  Yes

Was there a third party involved in the accident

No  Yes

Do you have a travel insurance which covers medical costs

No  Yes

At which health insurance company and under which policy number. \_\_\_\_\_

Date \_\_\_\_\_

Signature \_\_\_\_\_

*By signing this form I declare to accept the provided care on the declared bills.*