



Claim form for medical expenses (short version)

Please send this claim form to: ACE Europe:

avenue des Nerviens 9-31, bte 7, 1040 Brussels, BELGIUM, tel +32 2 516 97 83, fax +32 2 516 97 82.

Policy number:		E-mail address:	
Name and initials:			
Address:			
Postcode:			
Telephone:			
Bank or post office account number:			
Date of birth:			
Date and description of the complaint(s) / injur(y)(ies):			
Accident:	Yes / No		
Have you previously suffered from the same complaints? Yes / No			
If yes: on what date? Mention the first time:			
Name doctor:	Declaration nr.:	Declaration fee	Payment to:
			doctor insured
NB: You should send the original bills for all costs incurred			
Are you insured by a health care insurer? Yes / No			
If yes, please send to ACE Europe the evidence of the mutual health care insurer refund.			
The undersigned declares that he/she has answered the above questions and provided the above particulars accurately, truthfully and to the best of his/her knowledge, and that he/she has not withheld any particulars relating to this claim.			
Place:		Date:	
Signature:			