



82 rue Villeneuve
92587 Clichy cedex
FRANCE
Tel : +33 (0)1 42 81 97 00
Fax : +33 (0)1 42 81 99 03
admin@euroben.com

International Health Claim Form

EUROPEAN VOLUNTARY INSURANCE PLAN YOUTH IN ACTION PROGRAMME

Section A · VOLUNTEER – FREIWILLIGE/R – VOLUNTARIA/-O – VOLONTARIA/-O

I. PERSONAL DETAILS:

ID # / EVS Insurance		Date of birth (dd/mm/yyyy)	
Surname / Family name/s		First name(s), Middle name	
Your Email address	@	Your Phone	

II. ADDRESS DETAILS: *(It is necessary to fill in this part)*

	1- Permanent address in your country of origin	2 -Current address during EVS project
C/O, Chez		
Street #: Apartment #- Floor #		
Postal / ZIP Code		
City		
Country		

Confirm mailing address for any correspondence: 1 (country of origin) 2 (country of EVS project)

III. INTERNATIONAL BANK DETAILS

It is crucial to fill this section in case the money is to be transferred to your personal bank account # OR to your Organisation's bank account # OR any other third party's (i.e. medical providers) bank account #:

Name of the Bank Account Holder			
Bank's Name			
Complete address of the Bank			
Your complete account details for an international bank to bank transfer (i.e. IBAN)			
SWIFT Code / SORT Code / BIC		Account currency	

Section B – SERVICES / SUPPLIES (Use one line for each Medical bill)

Date of service	First Name of Patient	Description of Medical / Dental Services, Procedures or Supplies	Diagnosis or Cause for Medical Service	Charges & Currency	Practitioner / Facility
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					

If any of the bills is a result of an accident, please specify:
Circumstances of accident:

YES

NO

Section C - SIGNATURE

I hereby declare that the information made above is true to the best of my knowledge.

DATE:

Signature of Volunteer:

PROCEDURE FOR FILING A CLAIM:

If you are covered by French Social Security System or by the National Health Insurance, you must obtain reimbursement from French Social Security System or by the National Health Insurance before to become filling out this claim form. In this case, you may provide us with copy of all medical or dental bills duly paid and the original statement issued by the first line insurer.

HOW TO USE OUR SERVICES:

- Please keep a copy of your bills and claims for your records.
- Please attach original bills with detailed description of cares received, diagnostics, illness / injury, prescriptions for pharmacy, and Doctors' fees as well as proof of payment for each invoice paid.
- You must request **pre-approval** to avoid refusal for series of treatment (i.e. physical therapy) over 5 or more sessions.
- The claim must be submitted to us within **12 months** beginning from the date of medical service.
- We remind you that the exchange rate used for all medical reimbursements is the one provided by Natexis Bank and it is always related to the date of medical care, and not the date of the claim processing, which may be several months later.

Please send by the post your ORIGINAL CLAIMS to:

EUROPEAN BENEFIT ADMINISTRATORS

EVS

82 rue Villeneuve

92587 CLICHY Cedex - France

Phone : +33(0) 1 44 71 50 29