SERVICE CIVIL INTERNATIONAL

volunteering for peace

NGO Official partner of UNESCO (Consultative status) Participatory status with the Council of Europe

MEDICAL CLAIM NOTIFICATION FORM

Please complete this form in block letters (English/Dutch/French/German), keep a copy and post it to SCI Insurance (address below) within 48 hours after medical consultation.

INFORMATION ABOUT THE INSURED	FULL NAME	
	DATE OF BIRTH	
	NATIONALITY	
	HOME ADDRESS	
	EMAIL ADDRESS	
INFORMATION ABOUT THE PROJECT	NAME & LOCATION	
	NAME,EMAIL, ADDRESS OF COORDINATOR	
	SCI BRANCH / NATIONAL ORGANISATION	
START AND END OF INSURANCE PERIOD		FROM: TO:
OTHER INSURANCE	IS THE INSURED COVERED BY ANOTHER INSURANCE ? YES / NO	
	NAME, ADDRESS & POLICY NO AT THE OTHER INSURANCE	
	WHAT DOES THE OTHER INSURANCE COVER YOU FOR ?	
	HAVE YOU PLACED A CLAIM WITH THE OTHER INSURANCE ? YES, ON: NO BECAUSE:	

DESCRIBE WHAT HAS HAPPENED / HOW THE ILLNESS DEVELOPED:

NAME AND ADDRESS OF WITNESS(ES):

DATE AND PLACE:	SIGNATURE OF INSURED:	SIGNATURE OF COORDINATOR:

EMERGENCY PHONE:

00.32.3.2265727 (International Secretariat) or 00.32.484.108138 (Ossi Lemström)

The Association of Service Civil International ivzw
Belgiëlei 37
B-2018 Antwerp, Belgium

Tel:+32 (0)3 226 57 27
E-mail: finances@sci.ngo
www.sci.ngo

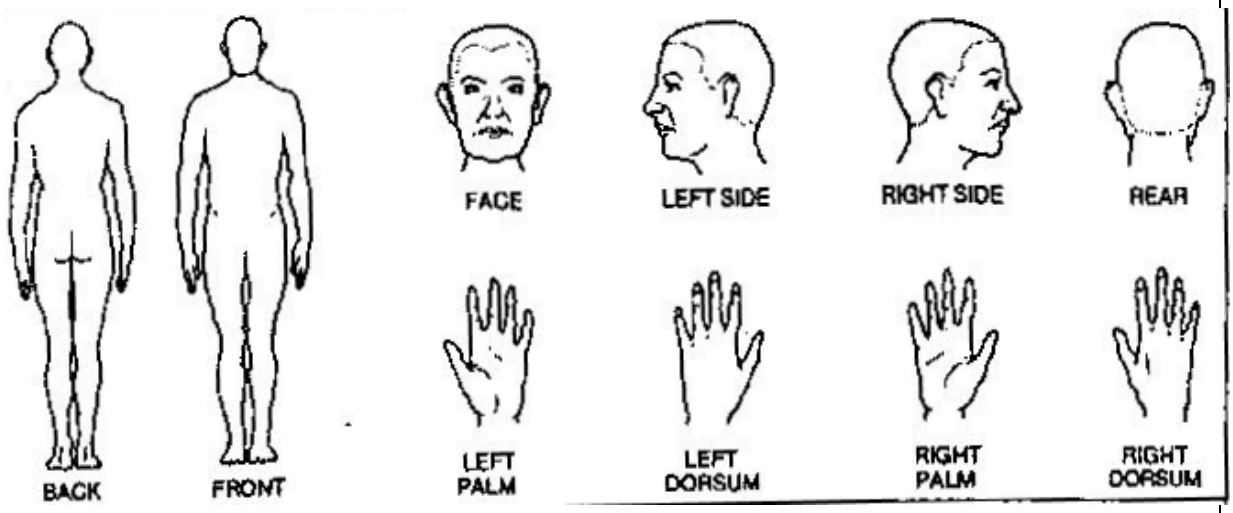
MEDICAL REPORT for SCI INSURANCE

PLEASE ASK THE MEDICAL DOCTOR TO FILL IN THIS PAGE OF THE FORM

INITIAL CONSULTATION	PLACE	
	DATE AND TIME	

INJURY

INDICATE NATURE & PLACE OF INJURY:



NEUROLOGICAL DAMAGE :

INTERNAL INJURIES :

ILLNESS

SYMPTOMS:

RELEVANT MEDICAL HISTORY:

RESEARCH

TEMPERATURE:	PULSE:
RESPIRATION:	BLOOD PRESSURE:
URINE ANALYSIS:	X RAY ANALYSIS:

DIAGNOSIS	FINAL / PROVISIONAL:

COULD THE INJURY/ILLNESS BE PARTLY OR ENTIRELY DUE TO PREVIOUS ILLNESS OR ACCIDENT ?
YES / NO, BECAUSE:

IS THE PATIENT UNABLE TO WORK ?
YES / NO, FROM: TO:

WILL THERE BE ANY LONG TERM IMPAIRMENT / DISABILITY ?
YES / NO, DETAILS:

ARE THERE ANY PRE-EXISTING CONDITIONS THAT MAY IMPAIR RECOVERY ?
YES / NO, DETAILS:

INITIAL TREATMENT:	FURTHER TREATMENT REQUIRED:
DOCTOR'S NAME & ADDRESS:	OFFICIAL STAMP
DOCTOR'S SIGNATURE:	