



**Summary claim form for medical expenses <250 EUR.**

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 last time: \_\_\_\_\_

*Are you insured by the mutuality cover ? Yes / No*

*If yes, please send to ACE Europe the evidence of the mutuality refund.*

Name doctor:	Declaration nr.:	Declaration fee	Payment to:	
			doctor	insured

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: \_\_\_\_\_