The Helsana Group comprises Helsana Insurance Company Ltd, Helsana Supplementary Insurance Ltd and Helsana Accidents Ltd.

Helsana

Enquiry regarding accident or illness during a stay abroad

Please send us the completed and signed form along with any supporting documents **within 30 days**:
Helsana Versicherungen AG, Postfach, 8081 Zürich

Insured Person

surname, first name

date of birth | e-Mail

insurance no.

phone (best availability)

Please answer the questions in full (questions 5-15 only in case of accident).

1. Where (country) did you become ill or have the accident?

2. Abroad
a. Reason for being abroad?
○ holiday ○ school/studies ○ business trip ○ posted worker
○ seeking medical treatment ○ secondary residence
other reasons:

b. Since when have you been abroad?
travel dates from: to:

c. Are you deregistered with your local municipal authority in Switzerland?
○ no ○ yes

3. Did you suddenly take ill?
○ no ○ yes
type of disease:

4. Did an accident occur?
○ no ○ yes

Accident details

5. Date of accident

6. Time of accident

7. Circumstances leading up to the accident

8. Time of accident
a. Were you employed at the time of the accident?
○ employed ○ apprentice ○ self-employed

b. If no, please explain?
○ not employed ○ school pupil/student
○ DI/OASI recipient ○ trainee

9. Do you receive or have you received unemployment benefit?
○ no ○ yes
from: to:

10. Number of working hours per week

11. Last employer before the accident?
from: to:

12. Were other persons involved in the accident?
○ no ○ yes
name and address

13. Was a police report made or a European Claim Form filled in?
○ no ○ yes
At which office or police station?

HEL-01-en-0123-0003-44144

Insured Person

surname, first name

insurance no.

Injury

14. Part of body injured

15. Type of injury

○ left ○ right

Further information

16. Details
a. Treatment period

from:

to:

b. Were you pregnant at this time?

○ no ○ yes

gestational age:

17. Payment
In which foreign currency were the invoices paid?*

18. Did you contact our emergency call centre?

○ no ○ yes

19. Were you receiving treatment before the stay abroad?

○ no ○ yes, why?

where?

how long?

* Please attach invoices. Please provide a brief description of content and currency amounts for illegible invoices or invoices in foreign languages. This will help us reduce translation costs and delays in processing claims.

Insurance

20. Insurances

a. Did you conclude separate travel insurance?

○ no

○ yes, with which company?

○ incl. coverage for treatment costs?

b. Are you covered by any other insurance?

○ no ○ yes

Type of insurance

○ extension of insurance ○ accident insurance pursuant to UVG

○ personal accident insurance

Name of insurance

c. Coverage for search, rescue or repatriation costs

○ ETI travel protection ○ credit card ○ Rega

○ others, which ones?

Authorisation / signature

I hereby confirm that I have answered the above questions truthfully and in full. By signing this form, I release hospitals, doctors and medical staff, public authorities, external emergency call centre, Swiss representations abroad, public offices and other insurers from their legal and contractual duty of confidentiality towards the insurer given in the letterhead and towards Helsana Supplementary Insurances Ltd and authorize them to disclose the information required in connection with the treatment. I also authorize the insurer given in the letterhead and Helsana Supplementary Insurances Ltd to hand over all the relevant documents for claims of recourse against the liability insurers or liable third parties involved.

place and date

signature of the insured person
or the legal representative

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**The Helsana Group comprises Helsana Insurance Company Ltd,
Helsana Supplementary Insurance Ltd and Helsana Accidents Ltd.**

Helsana

Invoicing in case of accident or illness during a stay abroad

Please send us the completed and signed form along with any supporting documents **within 30 days**:
Helsana Versicherungen AG, Postfach, 8081 Zürich

Insured person

surname, first name

insurance no. e-mail

Attachments ○ invoices ○ receipt for exchange rate

To be completed by the insured

Treatment date	Invoicing party (doctor, hospital etc.)	Treatment reason	Currency	Amount

Purchase date	Medication (product name)	Treatment reason	Currency	Amount

place and date

signature of the insured person
or the legal representative

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