

## **Claim Form**

Yes

Yes

Yes

Total amount of all invoices

€

Yes

Client information	Client number				
Please enter the details of the policyholder here. The policyholder is the person who has taken out the insurance.	Initial(s) Pre	rfix(es)	Last name  House  City/Town	number House number pr	efix
Explanatory notes	<ul> <li>Please fill in using block letters and clearly mark the boxes.</li> <li>Use a black or blue pen.</li> <li>Does this claim concern an accident involving another party? If so, please check the box 'Result of an accident'.</li> </ul>				
Important	<ul> <li>Transfer to own account: we will transfer the reimbursement amount to the bank account number known to us.</li> <li>Transfer to care provider: the reimbursement amount usually can be transferred to the care provider, although in some cases this will not be possible. If this is the case, you will see that we have transferred the amount to you on your reimbursement overview. Be aware that if you choose this option you are held responsible for making payment to the care provider on time.</li> <li>Claims for costs incurred abroad: please make use of the Claim Form for Expenses Abroad (Declaratieformulier buitenland) on www.vgz.nl for costs incurred abroad. You can request this form by telephone as well.</li> <li>Claims for transportation costs: please make use of the Claim Form for Transportation Costs (Declaratieformulier vervoer) on www.vgz.nl for reimbursement of transportation costs. You can request this form by telephone as well.</li> </ul>				
Sending claims:	<ul> <li>Please do not save up your invoices, but send them to us immediately.</li> <li>Enclose the original invoices with the claim form. We will not process photocopied, duplicate or reminder invoices.</li> <li>As your original invoices will not be returned to you, we recommend making a copy for your own administration.</li> <li>Please use our envelopes provided with our business reply number for claims. Did you fail to receive an envelope? Then send your claim to: Zorgverzekeraar VGZ, Postbus 25030, 5600 RS Eindhoven.</li> </ul>				
Invoice number/ reference number	r Initials	Who was treated?  Date of birth (DD-MM-YYYY)	Amount of the invoices	to my care	Result of an ccident?
			€ 00000. • 00000. • 00000.	Yes Yes Yes Yes Yes Yes Yes	Yes Yes Yes

For more information about your health care policy we refer to our website: www.vgz.nl
Claim forms are also available on this site for filling in and printing. If you do not have an Internet connection, please don't hesitate to call us.

Date of sending

Total number of invoices