CLAIM FORM

To handle your notification, SOS needs the following information, please write in capitals.
Guarantee of payment to the hospital/clinic for treatment will be assessed based on the below information.

Patient	National identification number	Name	
	Mobile phone number	Email	
Policyholder	National identification number	Name	
Insurance	**Home/Travel**	Name of insurance company	Policy Number
	Credit card[1]	Cardholder's name	
		Credit card No - XX - XXXX -	Type of card and issuing bank
	If the trip has been paid with the credit card, please inform; amount paid, date of payment and receiver of payment		
Itinerary	Date of outward journey	Date of scheduled return	Purpose of travel (i.e. holiday or business)
Medical Information	Date of first symptoms/injury	Country of injury	
	Date of admission or initial doctors visit	Have you previously experienced similar symptoms or illness? If yes, please specify date ☐ Yes ☐ No Date:	
Treating Facility	Name of facility	Phone No	
	Email	Attending physician/Treating doctor (name)	
GP/hospital in home country[2]	Name and of the patient's regular doctor/clinic in home country		Phone number

Consent
When your file has been opened in our systems, you will automatically receive an SMS requesting your consent to disclose necessary personal data to SOS International to secure the correct handling of your case. Please reply with "I hereby give my consent + your name" to this message as soon as possible. You can find more information regarding your consent on www.sos.eu/en/consent or by scanning the QR code on your cell phone:

Power of attorney
I hereby authorise Tine Poulsen (employee at SOS International) to apply for a temporary European Health Insurance Card (EHIC) on my behalf, if relevant for my case.
If SOS pays full compensation for my claim on behalf of my insurance company, I hereby transfer any claim against national/foreign health authorities, airline companies and/or travel agencies to SOS to apply for reimbursement of expenses on behalf my insurance company.

Date	I confirm that the information given in this form is true, complete and accurate. Signature of the patient/guardian

IMPORTANT! A medical report must be enclosed and must at least contain the following: Date of illness/injury, diagnosis, attending physician, estimated costs broken down into treatment, medicine, etc.

[1] Only relevant if credit card insurance
[2] Only relevant if you have previously experienced similar symptoms or illness