COMERGON S.A.
RISK MANAGERS | INSURANCE BROKERS

MEDICAL CLAIM FORM

Policy No.:..... **Insurer:**.....

Insured : .....

☐ **Accident** ☐ **Illness**

Date of treatment/accident:..... **Date of hospitalization :**.....

Hospital:.....

Nature of illness:.....

Detailed description of the accident:.....

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Please, send us attached:

1. Doctor's medical report
2. Bills
3. Hospital Invoices

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Ημερομηνία

Ονοματεπώνυμο-Υπογραφή