Notification of treatment abroad/illness

Insurance no.:

Please complete this form in full. This will allow us to process it more quickly and avoid any unnecessary questions.

Information on the insured person

First name: Last name:

Street, no.: Post code/place:

Private/mobile phone number: Business phone number:

E-mail address: Occupation:

Date of birth:

Responsible ÖKK agency:

Information on supplementary insurance (if applicable)

Have you concluded any travel insurance? ☐ yes ☐ no

If so, with which insurance company (please state name and address)?

Insurance number:

Last name and first name of policyholder:

Do you have any other health or accident insurance? ☐ yes ☐ no

If so, with which insurance company (please state name and address)?

Information on the stay abroad

Reason for stay abroad: ☐ Vacation ☐ Occupation ☐ Place of residence abroad ☐ Other reason

Length of planned stay: from to

ÖKK3022e/10.19

ÖKK Kranken- und Unfallversicherungen AG
Out-patient Benefits
Bahnhofstrasse 13, P.O. Box, 7302 Landquart
info@oekk.ch, 0800 838 000

Information on event

Date: Country/Place:

Reason for treatment: ☐ Illness ☐ Accident ☐ Maternity (in case of accident, enclose completed form)

As a result of: ☐ Emergency ☐ Check-up ☐ Further treatment ☐ Planned treatment

Did you contact our emergency call centre? ☐ yes ☐ no

Did you present your ÖKK insurance card? ☐ yes ☐ no

If so, did you contribute towards the costs of treatment when you were there?

If not, why not?

Detailed information on event

Type of complaint(s)/exact diagnosis: (please enclose medical report, if available)

Type of treatment: ☐ Out-patient at doctor's/hospital: from to

☐ In-patient in hospital: from to

Which treatments/medical measures were performed in detail?

Which medications were you given (please provide detailed list of individual medications)?

Did the aforementioned complaint exist before your departure? ☐ yes ☐ no

If so, from whom did you last receive treatment in Switzerland? (please state name and address)

Who is providing follow-up treatment in Switzerland? (please state name and address)

Did you have to be repatriated to Switzerland for medical reasons? ☐ yes ☐ no
(if so, please enclose confirmation of travel)

Date of repatriation:

Are you a Rega donor? ☐ yes ☐ no

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Costs

Invoice total: (please enclose original supporting documentation/receipt or bank debit confirmation)

in foreign currency: in Swiss francs:

Notes:

Please enclose the invoices. If the invoices are illegible or in a foreign language (with the exception of Italian, French and English), we request that you enclose a short summary of the content (translation) and invoice amounts in the respective local currencies.

The undersigned insured person or his/her legal representative hereby declares that he/she has answered all the above questions truthfully. He/She authorises us to obtain information from other insurers, doctors, police services and courts, and he/she authorises us to provide them with information.

Place/date: Signature of insured person/legal representative:

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