AIG Europe Limited (Finland Branch)
Kasarmikatu 44
FI-00130 Helsinki
Finland

Customer service: 0203 03456 (Mon-Fri 9-21, Sat 10-16)
Fax: 0207 010 180
E-mail: finlandclaims@aig.com

# CLAIM FORM
# GROUP ACCIDENT INSURANCE
# FOR THE RESIDENTS OF A HOUSING COMPANY

## INSTRUCTIONS FOR CLAIMANTS

Please fill in all sections of the form carefully.

To speed up the settlement of your claim, please enclose the following documentation: original receipts for any incurred expenses and available medical documentation.

When receiving medical care in Finland, the claimant is instructed to show their Sickness Insurance Card (Kela-kortti) to the medical service provider, who will deduct applicable benefits as per the Sickness Insurance Act from the insured's medical expenses.

The claim form and attachments should be sent to:
(no postage required)

AIG Europe Limited
Tunnus 5008951
00003 Vastauslähetys

## INFORMATION ON YOUR INSURANCE POLICY

The claim is based on the following insurance:

Finib Oy Group Accident Insurance for the residents of a housing company, policy numbers 2001023240 and 2001196438.

Name and address of the housing company:

## CLAIMANT'S PERSONAL DATA

| | | |
|---|---|---|
| Name | | Personal identity number |
| Street address | | |
| Postal code | City | Country, if other than Finland |
| E-mail address | | Telephone number |
| Account number (IBAN) | | The owner of the account, if not the claimant? |

By filling in your e-mail address above, you consent to AIG contacting you via e-mail during the handling of your claim.

## INFORMATION ON LOSS EVE

Did accident occur in the yard area on the way from home to work place, or on the way from work place to home? ☐

If yes, please apply first for compensation for medical expenses from workers' compensation insurance.

Time of loss (date and time)

Place of loss (exact location at the housing area)

Loss:

- ☐ Medical expenses due to an accident (2001023240)
- ☐ Permanent disability due to an accident (2001023240)
- ☐ Accidental death (2001023240)
- ☐ Personal property (2001023240
- ☐ KeyGuard (2001196438)
- ☐ Housing interruption (2001196438)

Detailed description of the loss event

## ITEMIZED CLAIM AMOUNT

| | | | |
|---|---|---|---|
| | € | | € |
| | € | | € |
| | € | | € |
| | € | Total | € |

## SIGNATURE

By providing your Personal Information to AIG in connection with your claim, you consent to the collection and processing (including the use and disclosure) of your Personal Information as described in this Privacy Policy available at www.aig.com/fi-privacy-policy or upon request. In particular you consent to the transfer of your Personal Information internationally. To the extent that you have provided (or will provide) Personal Information to AIG about any other individual, you certify that you have provided information to the individual about the content of this Privacy Policy and you are authorized to disclose his or her Personal Information to AIG as detailed in the Privacy Policy.

I declare that the information given in this notification is true and correct. For the purpose of this claim, I authorize the company to acquire whatever clarifications it may deem necessary from doctors, the Social Insurance Institution and any other establishments or persons processing information about me and my state of health.

Place and date

Claimant's signature

**AIG Europe Limited (Finland Branch)**
Kasarmikatu 44
FIN-00130 Helsinki, FINLAND

Business ID 2488582-7
T +358 207 010 100
F +358 207 010 180
www.aig.fi

**Claim for reimbursement** for medical care expenses / **Authorisation**

To be submitted to Kela / workplace sickness fund for reimbursement for medical care expenses in Finland and abroad

Claim number _____

| | | |
|---|---|---|
| INFORMATION ABOUT THE INSURED PERSON | Name | Personal identity no. |
| | Did the expenses result from<br>☐ a traffic accident? ☐ an occupational injury? | |
| AUTHORI-SATION AND SIGNATURE | I declare that the information I have given is true and accurate and authorise insurance company AIG Europe Limited to claim and collect any reimbursements payable under the Health Insurance Act.<br><br>Place and date<br><br>Signature and printed name of the claimant or of his or her provider or legal representative | |

Kela-approved form 1719e SV 07.11