

Claim

Extrasure medical treatment expenses insurance
 Extrasure medical expenses insurance
 Extrasure medical treatment insurance
 Other medical expenses insurance with a deductible

		Policy code (required)	
Insured	Name		Personal identity number
Claimant's address	Claimants name		Telephone (give mobile number, if available)
	Street address		Postal code Locality
	Email address		
Bank account details	Recipient of compensation (name)		
	IBAN		BIC
Clarification of illness / accident 1)	Date when illness started or accident occurred		Name of illness or type of symptoms
	Type of injury and how and in which circumstances the accident occurred		
	Have you previously had the same illness / injury? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify when?		
	Claim code if you have previously received compensation for the illness / injury		
	Was the illness or injury sustained <input type="checkbox"/> at work? <input type="checkbox"/> in leisure time? <input type="checkbox"/> in competitive sports or in training therefore?		What kind of competition / training?
Total expenses reduced by SII reimbursement 1)	Medical expenses		EUR
	Expenses incurred from physiotherapy		EUR
	Other expenses, specify		EUR
			EUR
	Total		EUR
Clarification of illness / injury 2)	Date when illness started or accident occurred		Name of illness or type of symptoms
	Type of injury and how and in which circumstances the accident occurred		
	Have you previously had the same illness / injury? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify when?		
	Claim code if you have previously received compensation for the illness / injury		
	Was the illness or injury sustained <input type="checkbox"/> at work? <input type="checkbox"/> in leisure time? <input type="checkbox"/> in competitive sports or in training therefore?		What kind of competition / training?
Total expenses reduced by SII reimbursement 2)	Medical expenses		EUR
	Expenses incurred from physiotherapy		EUR
	Other expenses, specify		EUR
			EUR
	Total		EUR

Clarification of illness / injury 3)	Date when illness started or accident occurred	Name of illness or type of symptoms
	Type of injury and how and in which circumstances the accident occurred	
	Have you previously had the same illness / injury? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify when?	
	Claim code if you have previously received compensation for the illness / injury	
	Was the illness or injury sustained <input type="checkbox"/> at work? <input type="checkbox"/> in leisure time? <input type="checkbox"/> in competitive sports or in training therefore?	What kind of competition / training?
Total expenses reduced by SII reimbursement 3)	Medical expenses	EUR
	Expenses incurred from physiotherapy	EUR
	Other expenses, specify	EUR
		EUR
	Total	EUR
Clarification of illness / injury 4)	Date when illness started or accident occurred	Name of illness or type of symptoms
	Type of injury and how and in which circumstances the accident occurred	
	Have you previously had the same illness / injury? <input type="checkbox"/> No <input type="checkbox"/> Yes, specify when?	
	Claim code if you have previously received compensation for the illness / injury	
	Was the illness or injury sustained <input type="checkbox"/> at work? <input type="checkbox"/> in leisure time? <input type="checkbox"/> in competitive sports or in training therefore?	What kind of competition / training?
Total expenses reduced by SII reimbursement 4)	Medical expenses	EUR
	Expenses incurred from physiotherapy	EUR
	Other expenses, specify	EUR
		EUR
	Total	EUR
Further information		
Consent	I hereby give my permission and authorize any medical practitioner or health care professional, hospital, health centre, clinic, occupational health care unit, mental health clinic, private nursing institution and any other medical and medically related facility as well as other insurance companies, insurance institutions and pension insurance institutions and any person in this same insurance company who has processed any claim I may have made under another insurance policy, to disclose to the insurance company any personal information related to my state of health which is necessary for the processing of a claim. In order to acquire the necessary information, the insurance company may give the above-mentioned parties detailed information concerning my state of health and my insurance.	
Signature	Place and date	Signature of the insured or his/her representative and name in block letters

CLAIMING COMPENSATION FOR MEDICAL EXPENSES

Fill in the claim form and attach expense related receipts. Compensation is paid on the basis of the terms and conditions related to your insurance. Read through the insurance terms and conditions and check in your insurance policy the maximum amount of indemnity, the amount of deductible and the maximum daily hospital charge.

Deductible

In case you claim compensation for several different illnesses or accidents simultaneously, fill in the section 'Clarification of illness/injury' for each loss event separately. Also itemise expenses for each loss event. Submit your claim to Pohjola for handling when the amount of coverable expenses exceeds the deductible. Note: the deductible may be either loss-specific or claim-specific.

Policy code / claim code

Always state the policy code of the insurance contract to which the insurance covering medical expenses is related. A claim code is stated only if the claim concerns the medical expenses of continued treatment pertaining to an insurance event (illness) which has already earlier been handled. A claim code is specified in the upper part of a claim settlement decision.

Clarification of illness or injury

State the date of falling ill and the name of illness (diagnosis) or the type of symptoms. In case the claim concerns an accident, specify the date of accident and how and in which circumstances the accident occurred.

Itemisation of expenses

Itemise the expenses on the claim form. In case you fill in an e-form, the amounts stated under the euro (EUR) column are automatically added to the sum total.

Attachments regarding expenses

Medical expenses are indemnified against original receipts. Each receipt must specify how expenses are formed.

According to the insurance terms and conditions, the claimant must first pay the medical expenses incurred and then claim for reimbursements as per the Health Insurance Act. Take copies of the documents sent to the Social Insurance Institution and attach them to this form together with the SII reimbursement decision.

If the reimbursements as per the Health Insurance Act have already been deducted at a medical centre, submit, in addition to the original receipt or cash receipt, copies of clarification forms and of examination or treatment orders.

When claiming compensation for medical expenses, attach to the claim form original pharmacy receipts and related medical prescriptions, copies of prescriptions or the pharmacy's invoices.

A medical statement may be necessary for the handling of a claim. In case you have a medical statement, case record or other statement where the diagnosis and other medical case history have been stated, attach a copy of such document to the claim form. Fees paid for statements are not coverable expenses.

Signature

Confirm the given data by signing the form. A claim of an insured who has reached the age of 18 must be signed by the insured himself/herself.

The claim form and the appendices should be sent to

Pohjola / Illness
P.O.Box 880
00013 POHJOLA
Finland

Should you need further information, please call the following number:

Call Centre +358 10 253 1333

Partner medical institutions

Should you need medical examination or treatment, we recommend that you see one of our partner medical institutions. You will find a list of our partners at www.pohjola.fi. In addition to our expertise and speedy service, we provide our partners with payment guarantees for costly medical procedures.