CAP WORKING HOLIDAY

WHAT TO DO IN THE EVENT OF A CLAIM?

HOW TO CONTACT OUR EMERGENCY DEPARTEMENT ?

HOSPITALIZATION, REPATRIATION, EARLY RETURN

Please indicate:
- Your first name and surname,
- Your contact details (address, telephone number)
- Your subscription number
- Your contract number IB1900383FRCA1

Call the assistance center available 24/7

+33 (0)1 41 85 93 16

MEDICAL EXPENSES REFUND

FOR THE REFUND OF MEDICAL EXPENSES

- a copy of your working holiday visa
- Your bank account details (IBAN)
- a copy of the national identity card
- Original and detailed bills along with the proof of payment
- Medical Prescriptions
- The medical filed compiled by the doctor stamped, dated and signed (document you received by email when you suscribed)
- In case of an accident: police report
- In case of hospitalization: hospitalization report And /or any proof of visiting the emergency room (report indicating the raison for your visit, the current and the future treatment).

For medical expenses < 500 €, please scan the invoices and report your claim online at:
www.chapkadirect.com/sinistre

For medical expenses > 500 €: please send the original documents in a sealed envelope addressed to the “medical advisor”:

Aon France / Chapka Assurances
31-35 rue de la Fédération
75015 Paris
France

Please keep the original documents, they may be requested by the Insurer.
Please make sure you get the report before leaving the hospital. Once you leave, it will be more difficult to get.

OTHER INSURANCE GUARANTEES (BAGGAGES, CIVIL LIABILITY, INDIVIDUAL ACCIDENT)

REPORT YOUR INCIDENT

Indicating the policy number IB1900383FRCA1 :
-Within 5 days for Civil liability and individual accident cover,
-Within 2 days for theft
In case of theft, the Insured person must file a complaint with the local authorities and within the 24 hours following the incident. In order to be covered, this complaint must include and describe the stolen objects.

ONLINE CLAIM REPORT

Please upload the documents to

Online:
http://www.chapkadirect.com/sinistre
We may request the original documents, please keep them.

CHAPKA
ASSURANCES
Cliquez. Assurez. Voyagez.

MEDICAL FILE
QUESTIONNAIRE MEDICAL
FORMULARIO MÉDICO

TO BE COMPLETED BY THE POLICY HOLDER / *À REMPLIR PAR L'ASSURÉ / A COMPLETAR POR EL ASEGURADO*

First and Last Name / *Nom et prénom / Nombre y apellidos :* ....

Contract number / *N° d'adhésion / N°de afilación :* ....

Date of Birth / *Date de naissance / Fecha de nacimiento* (d/j - m - y/a) : .... /........ /........

TO BE COMPLETED BY THE DOCTOR / *À REMPLIR PAR LE MÉDECIN / A COMPLETAR POR EL MÉDICO*

What ailment exactly does your patient suffer from? / *De quelle pathologie souffre le patient? / ¿Qué padece el paciente?*

If any, state the cause / *S'il y en a une, précisez la cause / Si hubiera un motivo, explíquelo :*

Date of the discovery of the illness / *Date d'apparition de la pathologie / Fecha de aparición* (d/j - m - y/a) ?
.... /........ /........

Is this the first episode? / *S'agit-il de la première manifestation de la pathologie ? / ¿Es la primera vez?*

How long has the patient suffered from this? / *Depuis combien de temps le patient souffre t-il ? / ¿Desde cuándo lo padece el paciente?*

Are there any associated pathologies? / *Existe t-il des pathologies associées ? / ¿Existe alguna patología asociada?*

Are there any related pre-existing pathologies? / *Existe t-il des pathologies pré-existantes ? / ¿Padece alguna patología preexistente?*

DOCTOR'S SIGNATURE /
SIGNATURE DU MÉDECIN /
FIRMA DEL MÉDICO :

Date / *Fecha* :

This information will be treated as private and confidential