## WHAT TO DO IN THE EVENT OF A CLAIM?

### HOW TO CONTACT OUR EMERGENCY DEPARTEMENT?

**HOSPITALISATION, REPATRIATION, EARLY RETURN**

Please indicate:
- Your first name and surname,
- Your contact details (address, telephone number).
- Your subscription number
- Your contract number 58223431

7 days a week 24 hours
+33 (0)1 41 85 93 16

### MEDICAL EXPENSES REFUND

**FOR THE REFUND OF MEDICAL EXPENSES:**

- A copy of your Student or internship visa
- A bank statement (IBAN)
- 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 subscribed)
- In case of an accident: police report
- In case of hospitalisation: hospitalisation report and /or any proof of visiting the emergency room (report indicating the reason for your visit, the current and the future treatment).

For medical expenses < 500 €, please scan the invoices and send them by email to:
chapka@medical-administrators.com

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

Chapka Assurances / MAI
Medical Administrators International
39, rue Anatole France
92532 Levallois Perret Cedex
France

Tél. : +33 (0)1 84 79 08 82

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 58223432):
- 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: https://www.chapkadirect.com/sinistre

We may request the original documents, please keep them.
First and Last Name / Nom et prénom / Nombre y apellidos: .................................................................

Contract number / N° d’adhésion / N° de afiliación: ..............................................................................................................

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

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 symptoms’ first manifestation / Date de la 1ère manifestation des symptômes pour l’assuré / Fecha de la primera manifestación (d/j - m - y/a): ........ /........ /........

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

Date in which the patient has been informed about the diagnosis / Date à laquelle le patient a été informé du diagnostic / Fecha en la que se ha informado al paciente sobre el diagnóstico (d/j - m - y/a): ........ /........ /........

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

This information will be treated as private and confidential