INSTITUTO NACIONAL DE SEGUROS

Personal Insurance

APPLICATION FOR BENEFITS

(Fill in with computer or printed characters)

Product's name: _____

Policy N°: | **Claim N°:**

INSURED' S INFORMATION

Direct Insured's Name: _____ _____ _____

FIRST SURNAME SECOND SURNAME NAME

Identification No.: _____ Telephone No.: _____ E-mail address: _____

Exact address or postal office box:_____

Direct Insured's IBAN: | | | | | | | | | | | | | | | | | | | | |

Currency: ☐ Colones ☐ Dollars ☐ Other: _____

I _____ identity document N° _____, authorize that the amount resulting from the medical expenses compensation presented, be deposited on customer account N°_____, Currency _____ of bank _____, to the name of _____ with identity document _____.

PATIENT' S INFORMATION

Patient's name: _____ _____ _____

FIRST SURNAME SECOND SURNAME NAME

Identification No.: _____ Age: _____ Date of Birth: _____

Profession or trade: _____ Gender: ☐ Male ☐ Female

RELATIONSHIP TO THE INSURED: ☐ Spouse ☐ Myself ☐ Son / daughter

Working in company or school attended: _____

Has medical insurance with another insurance company? ☐ YES ☐ NO

Company name _____ Policy N° _____

CLAIM' S INFORMATION

The claim resulted from: ☐ DISEASE ☐ ACCIDENT ☐ MATERNITY ☐ OTHER

Nature of illness or disease (detail of symptoms, if by an accident, where, why and how) Consequences _____

_____. First evident symptoms from the disease or accident: _____

_____

_____

Date:_____ Place:_____ Occupation:_____

Is the illness related to the patient's occupation?: ☐ YES ☐ NO

Indicate name and telephone No. of witnesses on the accident scene: _____

_____

If hospitalized mention hospital's name and number of days confined: _____

Name and residence of the physician (s) lending first assistance. Indicate if it is the Insured's regular one. In case of disease indicate the attending physician's name:"

NAME	ADDRESS	First consult date Day	month	year

I certify that the above answers are true and accurate to the best of my knowledge and authorize all physicians and other attending persons and all hospitals or any other institutions to provide the complete information (attaching complete copies of their files) related to this claim to the INSTITUTO NACIONAL DE SEGUROS (INS). Similarly, I authorize the appointed INS employees, to consult and compile all information contained in my files in any other hospital center, clinic or office whether private or belonging to the Caja Costarricense del Seguro Social.

Claimant's name and identification number	Signature	Date

AFFIDAVIT OF THE PRIMARY CARE DOCTOR

(Fill in with computer or printed characters)

PART B

Patient's name:	Age:

Clinical description (signs and symptoms) and progression of the same. In cases of accident provide detail of the trauma mechanism (description of the event).

Final etiological diagnosis (es).	Progression Date
_____	_____
_____	_____
_____	_____

Relate each one of your indications (tests, medications, etc.) to the diagnoses.

When did the patient consult you about this condition for the first time?

Has the patient experienced this disease previously? When?

How is this diagnosis related to other illnesses of the insured?

How long have you treated the insured as patient? For which diagnosis?

Describe the type of treatment, procedure or surgery practiced in detail.

Detailed cost of each procedure: With hospitalization? ☐ YES ☐ NO

Medical consult _____

Procedure _____ Cost of the procedure _____

Procedure _____ Cost of the procedure _____

Procedure _____ Cost of the procedure _____

Surgery _____ Cost of the surgery _____

Date and place performed:

Explain if another surgical intervention is expected in the future. Why?

Is the patient still treated for this diagnosis? (If discharged, indicate the date)

☐ YES ☐ NO Date discharged: _____

Date	Physician's name, telephone N° and complete address	Physician's signature

Note: if there is not enough space, you may add additional pages to detail; the same should be clearly identified with the patient's name and signed and sealed by the physician.
Please offer the insured reports of the studies performed to your patient, so they might provide photocopies of the same.