Please return completed form to O Driscoll O Neil
17/18, Herbert Place, Dublin 2
You can e-mail us at info@odon.com

MedI Cover expenses claim form	
Name of Student:	Date of Birth:
Name of attending School/College:	
Course Dates:	Contact Number:
Home Address: Email Address:	

Please provide a copy of your Medi – Cover certificate if available

If Accident please state fully:

(a) Where/When accident occurred:

(b) How the accident occurred:

(c) The injuries sustained:

If Illness, please state the full details of your illness:

Have you ever suffered from this illness before?

If YES, please give relevant information (dates etc)

Please state whether you were admitted to hospital:

If YES, please state dates: Admitted: Discharged:

Have you previously claimed under a similar policy?

If YES, please give details:

Please give name and address of attending General Practitioner:

Details of Expenses – all account, bills, receipts, medical certificates, any correspondence and any other documents relative to this claim should be forwarded with this claim form. These must all be originals.			
Nature of Expense	Name and Address of doctor or hospital attended	Amount €	Paid (Yes/No)
Total:			

Bank details	
Name on Account:	
Bank Name:	
Bank Address:	
Account number:	
Sort Code:	BIC:
IBAN number	

NB: If you have any further expenses as a result of this claim please forward immediately.

DECLARATION

I declare that all the information given is to the best of my knowledge and belief, full, true and correct.

Signed:_____ Date:_____