

REQUEST FORM FOR REIMBURSEMENT OF HEALTH SERVICES SELF-MANAGED BY SANEDIL

(Documentation for employees of Bodies, Associations and Organisations)

| Space reserved for operator Fo | ndo Sanedil | | |
|--------------------------------|-------------|------------------------|-------------|
| CODE FONDO SANEDIL | SN 00 | OPERATOR FONDO SANEDIL | (Last name) |

A) PERSONAL DATA OF EMPLOYEE REGISTERED WITH SANEDIL

| Name* | Last name* | | | |
|---|------------|------------|--|--|
| Born in* | Country* | City* | | |
| On*/ Fiscal code * | | _ | | |
| Address * | | | | |
| Country* | City* | Post Code* | | |
| Mobile Phone* | E-mail | | | |
| IBAN code of person who is registered, or who is co-registered with a registered person; 27 alphanumeric characters | | | | |
| | | | | |
| IBAN* _ | | . | | |
| Fields marked with * are mandatory. | | | | |

B) FILL IN THE SECTION BELOW ONLY IF THE REQUEST CONCERNS A FISCALLY DEPENDENT SPOUSE RESULTING FROM THE STATUS OF THE FAMILY, OR FISCALLY DEPENDENT CHILDREN

| PERSON FOR WHOM REFUND IS REQUEST | TED: | |
|---------------------------------------|--------------------|-----------|
| Name* | Last name* | |
| Born in* | On*// | |
| Fiscal code* _ _ _ _ _ _ _ | _ | |
| Address | Munici | pality |
| Post Code Country | | |
| Address (if different from residence) | | Post Code |
| Country | City | |
| Landline telephone number | Mobile phone numbe | r |
| E-mail | | |
| | | |



C) HEALTH SERVICES

| Tick the na | | the refund request and the copy documents that are attached | | | | | |
|---|---|---|--|--|--|--|--|
| | for cor | rective prescription lenses | | | | | |
| | Attach the following documentation | | | | | | |
| | | Copy of the certificate variation visus issued by an ophthalmologist/optometrist | | | | | |
| | | Copy of the expense document: invoice, detailed receipt | | | | | |
| AIDS/M | EDICA | L AI DS | | | | | |
| | | Wheelchair | | | | | |
| | | Orthopedic insoles | | | | | |
| | | Crutches, sticks, tripods, quadripods, and various walkers | | | | | |
| (Specify) | | | | | | | |
| | | Orthopedic bust | | | | | |
| | | Orthopedic corset | | | | | |
| | | Orthopedic braces/orthosis | | | | | |
| | | Abdominal container | | | | | |
| | | Orthopedic footwear | | | | | |
| | | Attach the following documentation | | | | | |
| | | Copy prescription from the specialist doctor | | | | | |
| | | (It must contain the diagnostic question or presumed or ascertained pathology that made the service necessary) | | | | | |
| | | Copy of the expense document: invoice/receipt issued by the supplier | | | | | |
| <i>must be pro te checks, In case of r appropriate be deducte</i> | esente the se receipt e check d in th | on attached to this request for reimbursement (invoices, receipts, medical prescriptions, etc.) d in photocopy format. Sanedil may, at its sole discretion, request at any time, for the appropria- nding of the original documentation, or further documentation in addition to that already sent. of false or counterfeit documents, SANEDIL will notify the competent judicial authorities for the rs and the ascertainment of any criminal liability. The health expenses incurred may, if necessary, e tax return only within the limit of the amounts not reimbursed by this Fund. | | | | | |
| Place and Da | ate | Signature | | | | | |
| | | La firma deve essere apposta per esteso e leggibile e non deve essere autenticata | | | | | |
| | | E MEMBER TO THE PROCESSING OF PERSONAL DATA FOR THE MANAGEMENT AND | | | | | |
| PROVISIO | N OF | SANEDIL SERVICES | | | | | |
| | : | | | | | | |
| The unders | - | | | | | | |
| and expres for the mar | ses con nageme | re read and understood the information published in the privacy section of the Sanedil website, nsent to the processing of personal data, including special categories of data relating to health, ent and provision of supplementary health and social-health care services and direct reimbur- ervices used. | | | | | |
| Place and D | Date | Member's Signature | | | | | |
| | | The signature must be affixed, in full and legible, and must not be authenticated | | | | | |



CONSENT OF THE FAMILY MEMBER TO THE PROCESSING OF PERSONAL DATA FOR THE MANAGEMENT AND PROVISION OF SANEDIL SERVICES FOR A FISCALLY DEPENDENT SPOUSE RESULTING FROM THE FAMILY STATUS, OR A FISCALLY DEPENDENT ADULT CHILD

In case of request of the Member for a fiscally dependent spouse, resulting from the family status / or fiscally dependent adult child:

(space reserved for the delegator*)

The undersigned_______as a fiscally dependent spouse, resulting from the family status, or as an adult child who is fiscally dependent on the Member, declares they have read and understood the information published in privacy section of the Sanedil website, and expresses consent to the processing of personal data, including the special categories of data relating to health for the management and dispensing of supplementary health and social-health care services and reimbursement in favour of the Member; also accepts that the Member is the only recipient of communications from SANEDIL and the only person authorized to upload refund requests and other documents in the reserved area, including data relating to health, directed to Sanedil through the Building Funds or EdilCasse.

Place and Date

Signature

The signature must be affixed, in full and legible, and must not be authenticated

* Attach a copy of the Delegator's identity document

PRIVACY POLICY IS AVAILABLE ON THE WEBSITE WWW.FONDOSANEDIL.IT PRIVACY SECTION