REQUEST FORM FOR REIMBURSEMENT OF HEALTH SERVICES SELF-MANAGED BY SANEDIL
(Documentation for construction company employees)

Space reserved for the cashier operator

CASSAEDILE/EDILCASSA _____ CNCE CODE _____

CONTACT OPERATOR _____
(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 _____

BLUE-COLLAR ☐ EMPLOYEE ☐

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 REQUESTED:

Name*_____ Last name*_____

Born in*_____ On*____/____/_____

Fiscal code* |__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|__|

Address_____ Country _____

Post Code_____ Municipality _____ _____

Address (if different from residence)_____Post Code_____

Country_____ City _____

Landline telephone number_____ Mobile phone number _____

E-mail_____

C) HEALTH SERVICES

Tick the nature of the refund request and the copy documents that are attached

☐ **FRAME** for corrective 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/MEDICAL AIDS**

- ☐ 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

The documentation attached to this request for reimbursement (invoices, receipts, medical prescriptions, etc.) must be presented in photocopy format. Sanedil may, at its sole discretion, request at any time, for the appropriate checks, the sending of the original documentation, or further documentation in addition to that already sent. In case of receipt of false or counterfeit documents, SANEDIL will notify the competent judicial authorities for the appropriate checks and the ascertainment of any criminal liability. The health expenses incurred may, if necessary, be deducted in the tax return only within the limit of the amounts not reimbursed by this Fund.

Place and Date

_____

Signature

_____

La firma deve essere apposta per esteso e leggibile e non deve essere autenticata

CONSENT OF THE MEMBER TO THE PROCESSING OF PERSONAL DATA FOR THE MANAGEMENT AND PROVISION OF SANEDIL SERVICES

The undersigned_____

declares they have read and understood the information published in the privacy section of the Sanedil website, and expresses consent to the processing of personal data, including special categories of data relating to health, for the management and provision of supplementary health and social-health care services and direct reimbursement on the services used.

Place and 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

POSSIBLE DELEGATION TO THE "FACILITATOR"

(Exclusively for requests submitted to the Cassa Edile/EdilCassa of reference)

The undersigned_____ as a member of the

Sanedil Fund do delegate Mr/Mrs/Ms/Miss_____

born in_____(Country and city), on the ___/___/_____

to deliver this request for reimbursement, including any related documentation attached, to the Cassa Edile/Edilcassa of reference, for the sole purpose of obtaining the services provided by the Sanedil Health Plan.

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