

# REIMBURSEMENT REQUEST FORM FOR THE SANEDIL FUND SELF-MANAGED HEALTHCARE SERVICES

## A) PERSONAL DATA OF THE MEMBER

| Name*  | Surname*   |  |
|--|--|--|
| Born in*   | Province*  | State*   |
|  | Tax Code*    _ _ _ _ _ _   | _ _ _ _  |
| *Mandatory field.  |  |  |
| I DECLARE THAT I WISH TO RECEIVE PAYMENTS FOR MY CLAIMS TO THE FOLLOWING BANK DETAILS  |  |  |
| Bank/Post Office:  |  |  |
| IBAN code of the Member, or jointly held with the Member; 27 alphanumeric characters   |  |  |
| IBAN*  |  |  |
| I AM NOT THE HOLDER OR JOINT HOLDER OF A BANK ACCOUNT<br>*Mandatory field.   |  |  |
| B) COMPLETE THE SECTION BELOW ONLY IF THE REQUEST CONCERNS A FINANCIALLY DEPENDENT<br>SPOUSE, RESULTING FROM FAMILY STATUS OR A FINANCIALLY DEPENDENT CHILD  |  |  |
| •  | REIMBURSEMENT IS REQUESTED   |  |
| Name*  | Surname*   |  |
| Born in*   | (Province)* on*  | _//  |
| Tax Code*  |  |  |
| *Mandatory field.  |  |  |
| AUTHORISATION - In case of a request by the Member for a financially dependent spouse, resulting from family status or a financially dependent adult child: (space reserved for the delegating person)   |  |  |
| The undersigned, as a financially dependent spouse resulting from family status or a financially dependent adult child of the Member, declares to have read and understood the information published on the Sanedil website Privacy Section, 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 healthcare services and reimbursement to the Member; also accepts that the Member is the sole recipient of communications from Sanedil and the sole person to submit reimbursement requests and other documents, including those containing health-related data, addressed to Sanedil through the "facilitators" and Special Construction Workers' Fund or EdilCasse. |  |  |
| Place and Date   | Signat   | ure of the Member's family member  |
|  |  | full and legible and does not need to be authenticated<br>elegator's identity document |
| DELEGATION TO THE "  | FACILITATOR"   |  |
| The undersigned*   | delegates Mr./Ms.*   | ĸ  |
|  | (Province)* on*/<br>tached documentation, to the relevant Cassa Edile/Ed |  |
| request, including any at<br>*Mandatory field.   | tached documentation, to the relevant Cassa Edile/Ed                     | dilCassa counter.  |
| Date Member's Signature  |  |  |
| Dute   |  |  |
|  |  | full and legible and does not need to be authenticated elegator's identity document    |
| <b>PERSONAL DATA OF THE REPRESENTATIVE OF THE SPECIAL CONSTRUCTION WORKERS' FUND/EDILCASSA</b> (to be filled in by the cashier worker only in the event of a request at the counter)   |  |  |
| Special Construction Wor   | kers' Fund/EdilCassa by  | CNCE Code  |
|  | /e Telephone N   |  |
| E-mail address of representative   |  |  |
|  |  |  |



### **C) HEALTHCARE SERVICES**

Tick the subject of the reimbursement request and the documents that are attached in copy

CORRECTIVE LENSES AND/OR FRAME

### Attach the following documentation

- Copy of certificate of vision correction/defect issued by an ophthalmologist/optometrist (the certificate does not need to be attached for the request for reimbursement of the frame only)
- Copy of the expense document: receipted invoice/itemised receipt (The document for the request for reimbursement of the frame only must indicate the adaptation of the corrective lenses in use)

### MEDICAL AIDS/DEVICES

- Orthopaedic braces/orthopaedic corsets
- □ Orthopaedic footwear and orthopaedic insoles
- Abdominal binder
- Wheelchair
- Crutches, canes, tripods, quadripods and various walkers
- Braces
- Orthosis

### Please attach the following documentation

- Copy of the specialist doctor's prescription (The prescription must contain the diagnosis or the presumed or confirmed pathology that made the service necessary)
- Copy of the expense document: receipted invoice/itemised receipt

### **PHYSIOTHERAPY REHABILITATION TREATMENTS**

### Attach the following documentation

- Copy of the specialist doctor's prescription
- Copy of the expense document: receipted invoice/itemised receipt (*The document must include the qualification of the doctor or healthcare professional*)

### SPECIALIST VISITS

(Guarantee can only be requested with reference to expenditure documents up to 31/12/2024. See the Fondo Sanedil website Guide Archive)

### Attach the following documentation

- Co
  - Copy of the expense document: receipted invoice/itemised receipt (*The document must include the qualification of the professional doctor*)

The documentation attached to this reimbursement request (invoices, receipts, medical prescriptions, etc.) must be submitted by means of photocopies. Sanedil may, at its sole discretion, request at any time for the appropriate checks, the sending of the original documentation or additional documentation in addition to that already sent. In the event 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 from the income tax return only within the limits of the amounts not reimbursed by this Fund.

#### By signing and submitting the appropriate privacy form, I declare that I have given Fondo Sanedil my consent to the processing of my personal data for the purposes set out in the specific information, which I have read.

Place and Date

### Member's Signature

The signature must be in full and legible and does not need to be authenticated