

EMPLOYER AND INSURED EMPLOYEE	Employer	
	Surname and forenames	Personal identification code
	Address	
	Postal code and post office	
	Bank account number for compensation	
REPORT ON MEDICAL TREATMENT EXPENSES	Treatment reasons (symptoms and diagnosis)	
	Attached is	number of treatment expenses receipts
AUTHORIZATION AND SIGNATURE	I affirm that the information given in this claim is correct. physicians, hospitals, nursing institutions, the social Insurance Institution as well as other insurance companies and institutions may provide Tapiola Mutual Life Assurance Company with information concerning my health and the insurance event.	
	Place and date	
	Insured's signature	Telephone number in the daytime

Tapiola-ryhmä
maksaa
postimaksun

Tapiola-ryhmä
Työntekijän hoitoturva-
vakuutukset
Henki/skannaus
Tunnus 5007453
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