

Settlements Office Address	Bruxelles - SC27 00/05
	○ Ispra - TP 740
	C Luxembourg - DRB B1/061

Joint Sickness Insurance Scheme				Caxembodig - DNB B17001						
MEMBER'S S	TAFF NUMBER:		Offi	ice address (hor	ne address if	retired):				
MEMBER'S S	URNAME AND FORENAMES:									
Telephone:										
e-mail:										
	to be sent in regular l Should you have already clai	ly and within th	ne time ses on-	e-limit of 18 m line, please do r	onths as of not submit the	•				
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• •	SEMENT NORMAL									
○ REIMBURS	EMENT for staff serving outside t	he European Uni	on							
○ REIMBURS	EMENT in case of RECOGNISED S	ERIOUS ILLNESS		ref. decision						
OCCUPATI	ONAL DISEASE date	of occupational dis	ease							
ACCIDENT	involving the member		invol	⁄ing a person insu −	red via the mei	mber (only if a third party is l	able)			
	date of the accident									
Date of expenses	Surname and forenames of beneficiary	Date of birth of beneficiary	Consu	e of expenses:	Amount of e	expenses in(2):	Other reimbourse ments (3)	Amount received from private		
			me	dicines, etc.	Country(1)	Amounts	ments (5)	insurance		
				-	_		<u> </u>			
				Total am						
Attach the original Encode one in Please remove	carry amounts over to another for ginal supporting documents and proice per line. e all staples from the annexes. our JSIS files, please use https://w	keep a copy of t	hem.	·	y.					
	te the amount in the currency us				all amounts (I	EUR, BGN, CHF, CZK, DKK,	GBP, HRK, H	UT, JPY, LTL		
	SEK, RON, USD). (To be specified, te the code of the country in whic				BG, CY, CZ, DI	E. DK. EE. ES. FI. FR. GR. HR	. HU. IE. IT. L7	Γ. LU. LV.		
MT, NL, PL	., PT, RO, SE, SI, SK, UK). (To be spe ements received from another sc	ecified, if not incl			, c., c <u>.</u> , c.	_, _ , , , , _ , , , , , , , ,	, , , , ,	., _0,,		
I, the unders	signed, certify that this claim, togethe all the invoices	er with the support have been paid for	-	uments, is correct	and that					
	(Membe	r's signature)	_							
	At	Da	ate							

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