

**OVERSEAS CONTACT**

Stijn Blommaert (NL) Pascale Domken (Fr)  
02 509 33 60 02 509 20 84

Timo Blyaert (NL) Amélie Elie (Fr)  
02 509 35 17 02 509 38 22

[periodiekeuitkeringen-osz@onsrszslss.fgov.be](mailto:periodiekeuitkeringen-osz@onsrszslss.fgov.be)  
[prestationsperiodiques-om@onsrszslss.fgov.be](mailto:prestationsperiodiques-om@onsrszslss.fgov.be)

**ADDRESS**

AD VII - Payments and Benefits Department  
Victor Hortaplein 11  
1060 Brussels

**CLAIM FOR PAYMENT OF SICKNESS AND DISABILITY INSURANCE BENEFITS /  
MODEL 1**

**A. IDENTIFICATION:**

**1. Claimant [insured person]:**

Surname: ..... Firstname: .....

Place and date of birth: ..... - \_\_\_\_/\_\_\_\_/\_\_\_\_

Nationality: .....

National registration no.: \_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_-\_\_\_\_ Registration number : \_\_\_\_/\_\_\_\_

Profession: ..... Civil status: .....

Residence – Street: ..... No.: .....

Postal Code: ..... City: ..... Country: .....

Telephone no.: ..... E-mail: .....

Disability type (tick) : The illness began on : \_\_\_\_/\_\_\_\_/\_\_\_\_

The accident took place on : \_\_\_\_/\_\_\_\_/\_\_\_\_

Delivery is expected/took place on : \_\_\_\_/\_\_\_\_/\_\_\_\_

Employment end date : \_\_\_\_/\_\_\_\_/\_\_\_\_

Is the illness a relapse? Yes No (Please check the correct answer)

**2. Spouse or cohabitant:**

Surname: ..... Firstname: .....

Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Nationality: .....

Date of marriage: \_\_\_\_/\_\_\_\_/\_\_\_\_ Profession: .....

**3. Dependent children under 25 years:**

	Surname	Firstname	Date of birth
1	.....	.....	____/____/____
2	.....	.....	____/____/____
3	.....	.....	____/____/____
4	.....	.....	____/____/____

**B. DOCUMENTS TO BE ENCLOSED WITH THE CLAIM:**

Statement from the health insurance company with which the insured person was affiliated before leaving for abroad (outside the EU) if participation in our insurance is less than 6 months.

Extract of the child's birth certificate, when applying for compensation for a maternity leave.

School certificate required for dependent children between 18 and 25 years old.

**OVERSEAS CONTACT**

Stijn Blommaert (NL) Pascale Domken (Fr)  
02 509 33 60 02 509 20 84

Timo Blyaert (NL) Amélie Elie (Fr)  
02 509 35 17 02 509 38 22

[periodekeuitkeringen-osz@onsrszslss.fgov.be](mailto:periodekeuitkeringen-osz@onsrszslss.fgov.be)  
[prestationsperiodiques-om@onsrszslss.fgov.be](mailto:prestationsperiodiques-om@onsrszslss.fgov.be)

**ADDRESS**

AD VII - Payments and Benefits Department  
Victor Hortaplein 11  
1060 Brussels

**C. BENEFITS WHICH THE CLAIMANT IS CURRENTLY RECEIVING:**

Description of the benefits which the claimant is obliged to declare	Amount	Period	Being paid by (exact name and address)
1. Leave allowance:			
2. Severance allowance or payment in lieu of notice:			
3. Retirement pensions or allowances:			
4. Compensatory payment in respect of accidents at work or occupational diseases:			
5. Benefits, grants or allowances provided on the basis of any sickness, invalidity or unemployment legislation:			
6. Do you receive benefits from the PCSW or FPS Social Security/ DG persons with disabilities?	Yes	No	

**D. MEDICAL COVERAGE:**

**1. Do you have health insurance (Health insurance fund or private insurance) other than OSZ insurance?**

Yes, name and address of insurance company: .....

No

**2. Do you receive the increased allowance? (BIM)**

Yes No

**3. Do you wish to continue paying the contributions for the existing OSZ 'Medical Care' contract?**

Yes No

**E. COMMITMENTS BY THE CLAIMANT:**

The claimant undertakes to inform the General Directorate VII Overseas Social Security of any change occurring in:

- (a) the composition of his/her family or the dependants resulting from it;
- (b) the details of the benefits listed under C above;
- (c) his/her resumption of work or registration as a job seeker (unemployment).

**F. BANK OR POSTAL ACCOUNT NUMBER INTO WHICH THE BENEFITS MAY BE PAID:**

Financial institution: .....

Account no.: \_\_\_\_/\_\_\_\_/\_\_\_\_

**The undersigned authorises the General Directorate VII Overseas Social Security to inform his/her employer - at the latter's request - of the amounts granted as sickness and disability insurance benefits (Please check the correct answer): Yes No**

I certify that this declaration is sincere and complete. I am aware that any false or incomplete declaration may lead to penalties being imposed (Royal Decree of 31 May 1933) and/or a recovery of the sums paid (Act of 17 July 1963).

Done at ..... on \_\_\_\_/\_\_\_\_/\_\_\_\_

Signature\*

(\* Both an electronic and a handwritten signature are allowed.

The data will be processed in compliance with the Act on the protection of privacy (Act of 30 July 2018). You may consult and rectify your data at any time. These data will only be used to process your claim.