CLAIM FORM

MEDICAL CLAIMS

Mac users should open the claim form in Adobe Reader in order to get the full functionality.

Personal data of policyholder

First name(s) Sex (M/F)

Family name(s)

Date of birth (day/month/year) Policy number -

Address

City Postal Code

State

Country

Telephone

Mobile phone

Fax

E-mail

Information about the trip

Purpose of the trip ◯ Leisure ◯ Business ◯ Combined

Travel destination

Please attach a copy of the travel documentation if the claim is submitted for Annual Travel

Travel period

From (date/month/year) **To** (date/month/year)

Information regarding the claim

The claim relates to ◯ Illness ◯ Injury/accident ◯ Dental ◯ Other

Where and when did the incident occur?

Country

Date (day/month/year)

Where you hospitalized? ◯ Yes ◯ No How many days?

Describe the course of the illness/injury/accident (including date of first symptoms)
(In case of an accident a police report may be requested)

Describe the symptoms (including date of first symptoms)
(If you have a medical report from treating doctor please attach to claim)

Have you previously had similar symptoms? ◯ Yes ◯ No

If yes, when?

Describe the symptoms:

Page 1 - Please continue on next page >

ihi Bupa ∘ Travel Sales ∘ Palaegade 8 ∘ DK-1261 Copenhagen K ∘ Denmark ∘ Tel: +45 70 20 70 48 ∘ Fax: +45 33 32 25 60 ∘ Email: travel@ihi-bupa.com ∘ www.ihi.com
24-hour emergency service ∘ Tel: +45 70 23 24 61 ∘ Email: emergency@ihi-bupa.com

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Details of your doctor in your country of permanent residence

Name of doctor

Address

Address

City Postal Code

Country

Telephone

Fax

E-mail

Authorisation to obtain medical information

I hereby give Bupa Denmark, filial af Bupa Insurance Limited, England, permission to seek and exchange any information from treating doctors and hospitals concerning my/our state of health as the Company deems necessary:

◯ Yes ◯ No

Other insurance

Do you have another insurance with Bupa Insurance limited? ◯ Yes ◯ No

If yes, please indicate policy number

Do you have medical insurance cover with another insurance company or with a credit card provider? ◯ Yes ◯ No

Name of insurance Company or credit card provider

Address

City Postal Code

Country

Policy number or credit card number

Has the claim been reported under other cover? ◯ Yes ◯ No

If no, please state why:

Page 2 - Please continue on next page >

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Details of the service provided (please complete if the information is not provided on the invoices)

Date of service	Diagnosis	Full name of insured	Description of procedures, medical services	Invoice charges (please state currency)	Charges paid by the insured	Charges oustanding to provider

Page 3 - Please continue on next page >

289E3-51v1.1_Claim Form_Travel_Medical Claims

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Payment method

The amount should be reimbursed to: ◯ Policyholder ◯ Provider ◯ Other

Name

Address Postal Code

City

State

Country

If no choice of reimbursement method has been made, ihi Bupa will send a cheque.
Your choice of reimbursement method cannot be changed after the claim has been processed.

The amount should be reimbursed in the following currency ◯ USD ◯ CHF ◯ EUR ◯ GBP

◯ **Please transfer reimbursement to the following credit card**

◯ Eurocard / Mastercard ◯ Visa ◯ JCB

Name of credit card holder

Card no.

Expiry date (month/year)

◯ **Please transfer reimbursement to the following account**

Name of bank

Address

BIC / S.W.I.F.T. Code / ABA number

IBAN

Account no.

Account holder

◯ **Please send a cheque to the following address if different from page 1**

Payee

Address Postal Code

City

State

Country

Please attach following documentation

- ○ Original report from police/doctor/dentist/hospital/emergency room
- ○ All invoices and corresponding receipts
- ○ Copy of air ticket/boarding card or travel certificate with information about the date of departure
- ○ Prescriptions of any medication, you are claiming for

Please submit this claim form along with the attached documentation to: traveleclaim@ihi.com

If you prefer post, please print the form and send it along with the attached documentation to the address below

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289E3-51v1.1_Claim Form_Travel_Medical Claims