

Claim Reference No.:

_____ - _____

AGA International S.A.
Niederlassung für Deutschland (Germany branch)
Claims Department
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Global Assistance



Claim Form for Foreign Travel Health Insurance

Please complete in full.

1. Personal details:

Please write your name in full.

Mr Ms _____
First name(s)

Street _____

Postcode / Place _____

Place of work _____

Telephone (home) _____

Date of birth _____

Native country _____

Surname(s) _____

Street Number _____

Country _____

Profession _____

Telephone (daytime) _____

e-mail _____

Nationality _____

2. Travel details:

Please submit copies of your insurance certificate, the insurance confirmation with proof that the premium has been paid (receipt) and your travel confirmation!

Destination _____

Commencement of journey / stay _____ End of journey / stay _____

Is accommodation available to you throughout the year at the destination? No Yes

Private travel Business travel

3. Details on the costs incurred:

Please submit bills, receipts and medical prescriptions as originals and copies of any foreign exchange receipts or credit card statements!

In which currency were the bills paid? _____

How were the bills paid? Cash payment Credit card Other payment _____

Please list all the bills here – even if these have already been submitted:

Doctor in charge or biller	Date of treatment	Total amount of bill (with currency denomination)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

4. Bank account:

Please state your bank connection if you have incurred costs.

Name of account holder: see 1. Other beneficiary: _____


First name _____ Surname _____


Account number _____ Bank code _____ Name of Bank _____

For transfers from abroad: _____

IBAN _____ Swift- / BIC-Code _____

5. Details of the course of the illness or the accident:

 In case of an illness, please submit a copy of the medical report or report on the findings / diagnosis, in case of an accident, also a copy of the accident report (if any).

Please describe in your own words when and how the complaints began and progressed, in case of an accident, how the accident happened:  Please use an additional sheet of paper if necessary.

When did the illness occur for the first time?

_____ Date at _____ o'clock

What was the doctor's diagnosis?

In-patient treatment at a hospital at the destination? No Yes

_____ from _____ to _____

Hospital / Clinic (Name and address)

Name of the doctor referring patient for in-patient treatment (First name / Surname)  Please enclose the discharge report of the hospital.

Was the in-patient treatment preceded by out-patient treatment (e.g. by the hotel doctor)?

No Yes

Were you ever treated for this illness before this journey / your stay?

No Yes

If yes, name and address of the doctor in charge

Which doctor treated you after you returned from your journey / your stay?

Name and address of the doctor in charge

Name and address of your family doctor

6 Additional information in case of an accident:

_____ Place of accident _____ Date of accident at _____ o'clock

First name / Surname of accident perpetrator

Address of accident perpetrator

Were there any witnesses who saw the accident?


No Yes

Mr Ms _____
First name / Surname 1st Witness

Address
 Mr Ms _____
First name / Surname 2nd Witness

Address

Was the accident taken down by the police?

 Please enclose any police report.

No Yes

_____ If yes, name and place of the police station _____ Reference number

7. Details of other insurance contracts:

Which statutory health insurance scheme or private medical insurance are you a member of?

Name of the health insurance scheme / medical insurance

Membership number

Address of the health insurance scheme / medical insurance

If you are covered by a statutory health insurance: Do you have a private additional insurance for in-patient treatment?

 No Yes

If yes, name of the private additional insurance company

Policy number

Address of the private additional insurance company

If you are covered by a statutory health insurance, please state the tariff you selected here if this differs from the standard tariff:

Do you have any other health or repatriation insurance with international cover (e.g. via the statutory health insurance, a credit card or your membership in ADAC automobile club, Red Cross, etc.)?

 No Yes

If yes, name of the company / association

Membership or Credit card number

Address of the company / association

Have you filed any other application for reimbursement with a different office (e.g. statutory or private health insurance, benefits office etc.)?
 ▶ Please submit proof of reimbursement if applicable. No Yes

Do you have a private accident insurance?

 No Yes

If yes, name of the insurance company

Policy number

Address of the insurance company

Have you ever claimed costs from a travel health insurance in the past?

 No Yes

Name and address of the insurance company

Name and address of the insurance company

8. Instructions on duty to tell the truth (Section 28 of the German Insurance Contract Act [VVG]):

The above details are true and have been given to the best of my knowledge. I have noted that intentionally false or incomplete details can result in a loss of insurance benefits and false or incomplete details provided through gross negligence can – depending on the seriousness of my fault – result in a reduction of insurance benefits, unless these details were not the cause of the determination of the insured event or the determination of the scope of the insurance company's liability for insurance benefits. The latter restriction shall not apply if the false or incomplete details were fraudulently provided by me.

Release from the duty to preserve secrecy

▶ Please also see overleaf if you are a member of a statutory health insurance in Germany.

I am aware that the insurance company may collect health data from the doctors giving treatment if this is necessary in order to ascertain its liability for insurance benefits or the extent of benefits and I have consented to the collection of such data. I therefore declare the following (please cross):

- I consent to the insurance company directly contacting the doctor or the hospital named in this claim form as well as the issuers of the invoices submitted in the event of any queries. I also consent to the insurance company contacting other personal insurers, statutory health insurance funds, German employers' liability associations, the person(s) causing the accident and the authorities for queries if knowledge of the data is required to ascertain its liability for insurance benefits. I release the insurance company's employees from their duty to preserve secrecy if the health data collected are transmitted to the employees of external consultants or medical experts to the extent required to examine the liability for insurance benefits. This declaration applies after my death and may be revoked at any time.
- I do not consent to a release from the duty to preserve secrecy at present. Instead, I will declare in writing whether I release the respective people or establishments from their duty to preserve secrecy in an individual case. I am aware that the decision for this option can lead to a delay in claims settlement, a reduction in benefits or even the insurance company's exemption from its liability for benefits if its liability cannot be ascertained or can only be ascertained in part based on the remaining sources of information.

Place / Date

Signature (Minors require the signature of a parent or guardian)

Declaration of assignment

Please fill in completely if you are a member of a statutory health insurance in Germany!

I hereby assign



Please write your name in full.

Mr

Ms

First name(s)

Surname(s)

Street

Street Number

Postcode

Place

my claims against my statutory health insurance

Name of the health insurance

Insurance number

Address of the health insurance

relating to the illness / the accident

from

in (Destination / Place)

to AGA International S.A., Ludmillastr. 26, D - 81543 Munich.

Place / Date

Signature (Minors require the signature of a parent or guardian)