

Claim Form

Your personal data:				
Name	First name			
Date of birth (DD/MM/YY)				
Address in home country:		Address in foreign country:		
I will return to my home country on (DD/MM/YY):	c/o			
Street	Street			
City ZIP code	City ZIP code			
State	State			
Country	Country			
Phone number	Phone number			
E-Mail address	E-Mail address			
Your medical treatment:				
Type of illness or accident				
If illness, have you had it before? If yes, when? If yes, when?				
In case of an accident own responsibility <input type="checkbox"/> caused by a third party <input type="checkbox"/>				
Reimbursement (the insured shall pay bank fees)				
Have you already paid the doctor's bill? yes <input type="checkbox"/> no <input type="checkbox"/>				
If no , payment will be made directly to the doctor/hospital				
Name of attending doctor/hospital				
Address of attending doctor/hospital				
If yes , you will receive reimbursement by wire transfer to your account				
Name of bank				
Address & country of bank				
Name of account holder	Account number	Bank Code		
SWIFT/BIC and IBAN (please indicate in any case)				
Claim documents				
<p>Send completed claim form with the original invoices to the claims office indicated below based upon your country of destination.</p> <p>INCOMPLETE OR WRONG INFORMATION WILL CAUSE A PAYMENT DELAY.</p> <p>If you travel to:</p> <table border="0"> <tr> <td style="vertical-align: top;"> <p>North and South America</p> <p>CareMed Claims CISI Claims Department River Plaza, 9 West Broad Street Stamford, CT 06902-3788 USA</p> </td> <td style="vertical-align: top;"> <p>Any other country excluding North and South America</p> <p>CareMed Claims ACE European Group Limited Direktion für Deutschland Lurgiallee 10 60439 Frankfurt, Germany</p> </td> </tr> </table>		<p>North and South America</p> <p>CareMed Claims CISI Claims Department River Plaza, 9 West Broad Street Stamford, CT 06902-3788 USA</p>	<p>Any other country excluding North and South America</p> <p>CareMed Claims ACE European Group Limited Direktion für Deutschland Lurgiallee 10 60439 Frankfurt, Germany</p>	<p>I hereby authorize any hospital, physician or other person who has attended or examined me, including those in my home country to furnish to the Assistance Center, or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photostatic copy of this authorization shall be considered as effective and valid as the original.</p> <p>Date</p> <p>Signature of insured</p>
<p>North and South America</p> <p>CareMed Claims CISI Claims Department River Plaza, 9 West Broad Street Stamford, CT 06902-3788 USA</p>	<p>Any other country excluding North and South America</p> <p>CareMed Claims ACE European Group Limited Direktion für Deutschland Lurgiallee 10 60439 Frankfurt, Germany</p>			