

Illness / Injury / Accident

Claim Form

(Please use block letters)

Duration of trip: _____	Date of departure: _____	Date of return: _____	
Purpose of trip:	<input type="radio"/> leisure	<input type="radio"/> work	<input type="radio"/> education

Information about the insured

First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
Address _____	
City _____	Postal Code _____
Country _____	Tel. daytime _____
Tel. evening _____	Fax _____
E-mail _____	
Student Travel Organisation _____	
Policy number _____	

Information about the claim

This claim is for illness injury accident other

Where did the illness/injury/accident occur? _____ Date _____

How did it take place?

In case of illness/injury

Please include a medical report stating the diagnosis and give your own full description of the course of the illness/injury (date of first symptom, etc.).

If you need extra space to give a full description, please continue on a blank piece of paper.

Have you previously had similar symptoms? Yes No

If yes, which symptoms and when?

Name of your doctor _____

Telephone _____

Address _____

In case of an accident

Please include a police report and describe the situation with your own words.

If you need extra space to give a full description, please continue on a blank piece of paper.

Names and addresses of witnesses, if any.

In case of treatment by a doctor

Date(s) of treatment _____ Name of doctor _____
 Address _____
 Telephone _____ Fax _____
 E-mail _____
 Please include all information from the doctor together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

In case of treatment at a hospital or an emergency room

Date treatment began _____ Date of discharge _____
 Name of hospital _____
 Name of treating doctor _____
 Address _____
 Telephone _____ Fax _____
 E-mail _____
 Kindly include all information from the hospital together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

Specification of expenses (if bills are included)

Please include all the original bills and a list where you specify the expenses.	Amount in local currency	Amount in reimbursement currency

Reimbursement

Please enclose the original itemised and receipted bills and travel documentation.

The amount should be reimbursed to: Policyholder Other
 Amount _____ Currency _____

Please transfer reimbursement to my credit card VISA Eurocard / MasterCard JCB
 Card no. _____ Expiry date (m/y) _____

Please transfer reimbursement to my account
 Name of bank _____
 Address _____
 BIC / S.W.I.F.T. Code / ABA, if any _____
 IBAN _____
 Account no. _____
 Account holder _____

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

Information about other insurance

Do you have a similar insurance cover with another company? Yes No
 If yes, name of company: _____ Address: _____
 Policy no.: _____ Has the claim been reported to the other company?: Yes No

Must be signed by the insured

I, the undersigned, declare that all information given in this Claim Form is in accordance with the truth and that nothing is concealed. I authorise International Health Insurance danmark a/s (the Company) to obtain information from any doctor, hospital or insurance company concerning myself or any co-insured persons in order to process the claim in accordance with the Policy Conditions.

I hereby accept that the Company will record the information given for the purpose of processing data in connection with e.g. premium collection, processing of claims, reimbursements etc. In case of non acceptance of the request for reimbursement, the information given may be recorded. The Danish Act on Processing of Personal Data allows me the right of access to see documents and information recorded. Furthermore, I accept that insurance correspondence which does not contain health information or other sensible information is sent to the person registered as the policyholder.

Date: _____ Signature: _____