A member of the BUPA group

Illness / Injury / Accident

Claim Form

International Health Insurance danmark a/s

(Please use block letters)

Please mail to: If you are in the US: ihi Bupa, 7001 SW 97th Ave, Miami, FL 33173, USA
In all other countries: 8, Palaegade, DK - 1261 Copenhagen K, Denmark

Duration of trip: Date of departure _____ Date of return _____

Purpose of trip: ❍ leisure ❍ work ❍ education

Information about the insured

First name(s) _____ Date of birth (day/month/year) _____

Family name(s) _____ Sex (M/F) _____

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.

_____

_____

Please continue on page 2

IHI Student Travel

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: _____