BUPA GLOBAL

CLAIM FORM

This claim form should be sent together with the receipted bills indicating dates of treatment with itemised pricing.

(Please use block letters)

PERSONAL DATA

Policy number	-
First name(s)	
Family name(s)	
Sex (M/F)	Date of birth (dd/mm/yyyy) Age
Address	
Postal code	
City	
Country	
Telephone	
Mobile phone	
Fax	
Email	

OTHER HEALTH INSURANCE

Have you made a claim or are you making a claim against any other insurance company or benefit plan? ◯ YES ◯ NO

If yes, please complete the following:

Company name	
Address	
Policy number	

Bupa Global ∘ Customer Service ∘ Palægade 8 ∘ DK-1261 Copenhagen K ∘ Denmark ∘ Tel: +45 70 23 00 42 ∘ Fax: +45 33 32 25 60 ∘ Email: ihi@ihi.com ∘ www.ihi.com

Bupa Global Assistance ∘ Tel: +45 70 23 24 60 ∘ Tel: Email: emergency@ihi.com

PAYMENT METHOD

◯ **Please transfer reimbursement to my account:**

Name of bank

Address

BIC / SWIFT Code / ABA, if any

IBAN

Account no.

Account holder

Expiry date (only credit card)

Reimbursement currency

Please register my bank account info. for future reimbursement ◯ YES ◯ NO

◯ **Please send me a cheque:**

Payee

Reimbursement currency

SEND THE REIMBURSEMENT STATEMENT BY EMAIL

If you have chosen a transfer you can choose to have the Reimbursement Statement sent to you by email.

Please send Reimbursement Statement by email: ◯ YES ◯ NO

If yes, please write your email address:

Email

TO BE COMPLETED IN CASE OF ILLNESS

Details of the diagnosis:

Diagnosis or type of illness:

Date of first consultation for this diagnosis: (dd/mm/yyyy)

Have similar symptoms occurred previously? ◯ YES ◯ NO

Please include complete medical information.

TO BE COMPLETED IN CASE OF ACCIDENT / INJURY

Details of the accident / injury:

Type of accident / injury:

Date of accident / injury: (dd/mm/yyyy)

Date of first consultation for this accident / injury: (dd/mm/yyyy)

Have similar symptoms occurred previously? ◯ YES ◯ NO

Please include complete medical information.

IN CASE OF HOSPITALISATION

Name of hospital:

Address

Postal Code City

Email

Country

Period of hospitalisation (dd/mm/yyyy)

DETAILS OF THE SERVICE PROVIDED *(Please complete if the information is not provided on the invoices)*

Dates of services (dd/mm/yyyy)	Diagnosis	Description of: Procedures, medical services and supplies furnished	Currency	Charges
Total Charges:				
Amount paid by the insured:				
Amount paid by other insurance:				
Balance due to hospital/clinic/doctors, etc:				

MUST BE SIGNED BY THE INSURED OR THE TREATING PHYSICIAN

(by parent or treating physician if insured is under the age of 18)

I, the undersigned, declare that all the information given in this claim form is in accordance with the truth and I authorise Bupa Global to obtain information from any doctor, hospital or insurance company concerning myself or the persons insured under this policy in order to process the claim in accordance with the Policy Conditions.

Full name in capital letters:

Date _____ **Signature** _____