



B D A E G R U P P E

PAYMENT OF INSURANCE BENEFITS EXPAT®36/60 US 1000

# CLAIMS REIMBURSEMENT FORM

**INSURED PERSONS ON THE AMERICAN CONTINENT PLEASE DIRECT ALL QUESTIONS CONCERNING APPROVAL OF BENEFITS AND CLAIMS SETTLEMENT AS PER INSTRUCTION SHEET TO:**

**EURO CARE • PO BOX 4610 • SEMINOLE, FL 33775, USA  
FON: +1-727-593-5462 • FAX: +1-727-593-5973  
E-MAIL: EUROCARE@TAMPABAY.RR.COM**

**ALL MEMBERS OUTSIDE THE AMERICAN CONTINENT ARE REQUESTED TO COMPLETE THE FOLLOWING FORM AND THE TABLE ON THE REAR SIDE IN ORDER TO APPLY FOR REIMBURSEMENT OF CLAIMS. PLEASE COMPLETE ONLY ONE FORM PER PERSON AND SEND IT TO:**

**BDAE HOLDING GMBH • KÜHNEHÖFE 3 • D-22761 HAMBURG**

<b>PARTY ENTITLED TO INSURANCE:</b>		
Surname:		First name(s):
Current address (street, ZIP, city, country):		Use as address for service*: <input type="checkbox"/> Yes <input type="checkbox"/> No
Phone (with country and local code):	Fax (with country and local code):	e-mail:
<b>PAYMENT DETAILS FOR REIMBURSEMENT:</b>		
Account holder:		
Bank:	Account no.:	Sort code:
<b>ADDITION FOR FOREIGN ACCOUNTS:</b>		
Bank adress:	BIC/Swift:	IBAN:
<b>INFORMATION ON OTHER ACTIVE HEALTH INSURANCE:</b>		
Does the insured person have additional health insurance*? <input type="checkbox"/> No <input type="checkbox"/> Yes, with:	Insurance no.:	
Since when is the insured person staying abroad? (*please tick)	Current occupation of the party entitled to insurance abroad?	

Stand: 14.04.2010

**PLEASE ENLIST THE CLAIMS TO BE REIMBURSED IN THE TABLE OVERLEAF, RESPECTIVELY LET IT BE COMPLETED BY THE ATTENDING PHYSICIAN!**

**FOR QUERIES PLEASE CONTACT:  
SABRINA RICKER  
PHONE: +49-40-30687411 • FAX: +49-40-30687490  
E-MAIL: LEISTUNG@BDAE.DE**

