



B D A E G R U P P E

PAYMENT OF INSURANCE BENEFITS EXPAT® RETIRED

CLAIMS REIMBURSEMENT FORM

**PLEASE 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

PARTY ENTITLED FOR INSURANCE:		
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:
PAYMENT DETAILS FOR REIMBURSEMENT:		
Account holder:		
Bank:	Account no.:	Sort code:
ADDITION FOR FOREIGN ACCOUNTS:		
Bank adress:	BIC/Swift:	IBAN:
INFORMATION ON OTHER ACTIVE HEALTH INSURANCE:		
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 (only necessary on first submission of claims)? (*please tick)		

Stand: 01.04.2010

**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**

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