Medical Claims

Claim Form for e-claiming

Please submit this claim form along with your bills to: traveleclaim@ihi.com

Personal data of policyholder

First name(s) | Sex (M/F)

Family name(s)

Date of birth (day/month/year) | Policy number | -

Address

City | Postal Code

State

Country

Telephone

Fax

E-mail

Travel Period

From (date/month/year) | **To** (date/month/year)

Information about the trip

Purpose of the trip ◯ Leisure ◯ Business ◯ Combined

Travel destination

Date of departure (day/month/year) | Scheduled date of return (day/month/year)

Please attach a copy of the travel documentation

Information regarding the claim

The claim relates to ◯ Illness ◯ Injury ◯ Dental

Where and when did the incident occur?

Country

Date (day/month/year)

Describe the course of the illness/injury

Describe the symptoms

Have you previously had similar symptoms? ◯ Yes ◯ No

If yes, when?

Diagnosis

Details of your doctor in country of permanent residence

Name of doctor

Address

Address

City | Postal Code

Country

Telephone

Fax

E-mail

Please continue on next page

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Bupa Insurance Limited is authorised and regulated by the Financial Services Authority (UK)

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Authorisation to obtain medical information

I hereby give Bupa Denmark, filial af Bupa Insurance Limited, England, permission to seek and exchange any information from treating doctors and hospitals concerning my/our state of health as the Company deems necessary:

◯ Yes ◯ No

Other insurance

Do you have insurance cover with another company? ◯ Yes ◯ No

Name of insurance Company

Address

City Postal Code

Country

Has the claim been reported to the other company? ◯ Yes ◯ No

Details of the service provided (please complete if the information is not provided on the invoices)

Date of service	Diagnosis	Full name of insured	Description of procedures, medical services	Invoice charges (please state currency)	Charges paid	Charges oustanding to provider

Please continue on next page

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Payment method

The amount should be reimbursed to: ◯ Policyholder

◯ Other

The amount should be reimbursed in the following currency

◯ **Please transfer reimbursement to the following credit card**

◯ Eurocard / Mastercard ◯ Visa ◯ JCB

Card no.

Expiry date (month/year)

◯ **Please transfer reimbursement to the following account**

Name of bank

Address

BIC / S.W.I.F.T. Code / ABA, if any

IBAN

Account no.

Account holder

◯ **Please send a cheque to the following address if different from page 1**

Payee

Address Postal Code

City

State

Country Currency

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

Submit by e-mail

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