



**INDEMNIFICATION FORM MEDICAL EXPENSES**

Please read the instructions in the event of claim carefully (fill in your file number as stated on your insurance card)  
**FILE NUMBER** ..... **WEP EXTENDED COVER**

**IMPORTANT!**

Claims for medical expenses can only be dealt with if the indemnification form is filled in completely and if it is accompanied by original bills. PLEASE SEND ALL CLAIM FORMS WITHIN 30 DAYS! Keep a photocopy of your bills and receipts.

**Name** .....  
**Address in country of origin** .....  
**Date on which illness started or accident took place** ...../...../.....  
**Type of illness and/or accident** .....  
**Temporary address abroad** .....  
**Period of insurance** from ...../...../..... to ...../...../.....  
**Period of travel** from ...../...../..... to ...../...../.....  
**Date of birth** ...../...../.....  
**Type of cover: WEP EXTENDED COVER**.....

**THIS PART TO BE FILLED IN BY DOCTORS**

**Kind of illness and/or accident** .....  
**Dates of visits**  
**to doctors** .....  
**to chemists** .....  
**Diagnosis** .....  
**Recovered?** yes no  
**Hospital treatment necessary?** yes no  
**Ambulance used?** yes no  
**Signature of doctor** .....

**THIS PART TO BE FILLED IN BY INSURED**

**Total claim amounting to (please indicate currency)** .....  
To be paid to  
**Name** .....  
**Address** .....  
**(International \*) Bank account number** .....  
\* please mention the IBAN (International Bank Account Number) & BIC (Bank Identifier Code)

Are you insured for medical expenses elsewhere? (NHS/Private health insurance) yes no  
With which insurer/national health scheme and under which policy number? .....  
Will you receive indemnification from above mentioned company? yes no  
If not, why not? (attach written denial)  
I declare that the information in this claim is correct and true.  
Place: ..... Date: ...../...../..... Signature of the insured.....