Please send your documents to:

Advigon Versicherung AG
Claim-Services
20911 Hamburg

Insurance no.:

Person treated:

Health Insurance - information on an insured event for foreign visitors

Please complete all fields accurately and legibly. Please note that failure to provide correct or complete information may render your insurance cover invalid (for more on this, read the last Section)

General

Please attach proof of insurance and proof of the premium payment.

Details on the claimant and the trip:

Family name, first name : _____ Date of birth: _____

Nationality (nationalities): _____

Occupation/work performed at the date of the illness or injury: _____

Employer at the date of the illness or injury: _____

Street and house number: _____

Postal code/Town:: _____ Country: _____

Email/fax: _____ Phone (private with code): _____

Mobile phone: _____ Phone (work with code): _____

Details on benefits be paid:

Account holder: _____

Name and place of bank: _____

Bank sort code/BIC/SWIFT/branch code: _____

Account/IBAN no.: _____

Details on your entry:

Date of your entry into the EU/Germany: _____
Please attach a copy of your bus, rail, plane tickets, your reservation confirmation or the stamp of arrival/departure in your passport.

Which country were you treated in? _____

When will you return to your native country? Date: _____

Advigon Versicherung AG
Postfach 1130, Drescheweg 1
9490 Vaduz, LIECHTENSTEIN
www.advigon.com

Insurance no.:

Details on the insured event:
Please submit originals of doctors' bills, prescriptions and receipts. If payment has already been made, e.g. by your statutory health insurer, it is sufficient to submit a copy with a note of the reimbursement. In the case of in-patient treatment, please attach a copy of the discharge report.

In the case of illness or accident:

a) What was the illness for which you had treatment? Please describe the diagnosis in your own words.

_____

_____

_____

b) When did the complaints first arise? Date: _____

In the case of check-up or vaccination:

☐ check-up ☐ vaccination

In the case of dental treatment:

a) Did you have toothache? ☐ yes ☐ no

b) Did you get dentures, crowns, onlays, etc.? ☐ yes ☐ no

c) If yes, where? ☐ Upper right ☐ Lower right ☐ Upper left ☐ Lower left

d) When did the complaints first arise? Date: _____

In the case of treatment due to pregnancy:

a) When was the pregnancy determined? _____

b) In which week of pregnancy was the pregnancy determined? _____
Please attach a complete copy of the pregnancy medical records.

c) Why were you treated during the pregnancy?
☐ check-up ☐ complaints/early labour ☐ premature birth ☐ delivery

d) In case of complaints during pregnancy:
When did the complaints first arise? Date: _____

In the case of death:
Please provide details of the date and cause of death. Please attach a copy of the death certificate.

_____

_____

More details on the insured event:

a) When did you first receive medical treatment? Date: _____

b) Please name all the doctors who treated you during your stay abroad (name, address, telephone number, fax number, email adress). If there is insufficient space, please attach a separate sheet.

_____

_____

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c) Had you already received medical treatment for the illness before the start of the journey? ☐ yes ☐ no

d) Was the treatment the consequence of an illness or accident treated before the start of the journey? ☐ yes ☐ no
If yes, please give us details of the doctors providing treatment (date, name, address, telephone number)

_____

_____

e) Who is or was your family doctor/dentist/specialist doctor in the last 12 months before the start of the journey? Please give us details of the names and addresses of the doctors, the treatment periods and the diagnoses. If there is insufficient space, please attach a separate sheet.

_____

_____

_____

f) Prior to the start of the journey, did you have complaints or illnesses that were not treated? ☐ yes ☐ no

If yes, what were these complaints or illnesses? _____

Details in the case of accident:

a) Place of accident (street, house number, place): _____

_____

b) Date of the accident: _____ Time of the accident: _____

c) Please describe how the accident happened:

_____

_____

_____

d) Was the accident caused by another person(s)? ☐ no ☐ yes

If yes, please give us name(s) and address(es):

_____

_____

_____

e) Did the accident happen at your place of work, during work time or at your school during lessons or a school event? ☐ no ☐ yes

f) Did the accident happen on your way to your place of work/school or from work/school to your home? ☐ no ☐ yes

g) Have the invoices on the accident-related treatment already been submitted to the person causing the accident or to that person's liability insurer for reimbursement? ☐ no ☐ yes

If yes, to (Name, address, insurance number of the liability insurance):

_____

_____

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h) Are there witnesses to the accident? Please give names and addresses: ☐ no ☐ yes

i) Which police station dealt with the accident? Please give us details of the police station and reference number and attach a copy of the police report.

Details on further insurance policies:

a) Have you been insured by us in the past? ☐ yes ☐ no

If yes, when and what was the policy number?

b) Which other insurance company has given you health insurance cover in the last five years?

(name, address, policy number)

c) Have the invoice documents submitted to us been submitted to another insurance company? ☐ yes ☐ no

If yes, please attach a copy of the other insurance company's settlement letter.

d) Have you submitted medical invoices for reimbursement to another insurance company in Germany in the last five years? ☐ yes ☐ no

If yes, please give us details of the year, country in which you were treated, name, address and policy umber of the insurance company:

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Information under Sec. 28 para. 4 VVG

Information on the consequences of breach of duty after the insured event

Dear customer,

once the insured risk has occurred, we require your assistance.

Duties to provide information and assist in clarification

On the basis of the contractual documents entered into with you, we may demand, after the occurrence of the insured risk, that you provide us with all information that is necessary to determine the nature of the insured risk or the scope of our liability (duty to provide information) and to provide us with all details that serve to clarify the matter (duty of clarification) to enable us to properly assess our liability. However, we may also demand that you provide us with supporting records/documents provided that such demands are reasonable.

Loss of benefits

If, contrary to the contractual agreements, you wilfully provide no information or incorrect information or wilfully fail to provide us with the supporting records/documents that we request, you will lose your entitlement to the insurance benefits. If your breach of these obligations is based on gross negligence, you will not fully lose your entitlement, but we may reduce the benefits in proportion to its seriousness. There will be no reduction if you prove that you have not been grossly negligent in infringing the obligations.

Despite a breach of your obligations to provide information or assist in clarification or provide supporting records/documents, we will still be obliged to pay benefits insofar as you can prove that the wilful or grossly negligent breach was not the caused by the investigation of the insured event or by the investigation of the scope of our liability.

If you fraudulently breach the obligation to provide information, to clarify matters or to provide supporting records/documents, we will in all cases be released from our liability to pay benefits.

Note

If a third party and not you yourself is entitled to the benefits under the contract, such third party must also provide information, assist in clarifying matters and provide supporting records/documents.

Final statements

I confirm that the information I have provided above is true and complete. I am aware that incorrect or incomplete information may lead to loss of cover. I have taken note of the above information in accordance with Sec. 28 para. 4 of the Insurance Contract Act.

In addition I assign my claims and demands against a party causing the accident/liable party or against my statutory health insurance fund/private health insurer in the amount of the benefits paid by Advigon Versicherung AG to Advigon Versicherung AG.

Place/Date	Signature of Policyholder	Signature of Insured person (or legal representative)

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