Claim Reference No.:

AGA International S.A.
Niederlassung für Deutschland (Germany branch)
Claims Department
Bahnhofstraße 16 · D - 85609 Aschheim b. München
Phone: +49.89.6 24 24-297
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Global Assistance

Allianz

Claim Form for Foreign Travel Health Insurance

Please complete in full.

1. Personal details:

Please write your name in full.

☐ Mr ☐ Ms

First name(s)

Surname(s)

Street

Street Number

Postcode / Place

Country

Telephone /Mobile

e-mail

Date of birth

Insurance number (policy number, annual insurance number or credit card number)

2. Bank account

Who is entitled to receive the insurance benefit?

☐ see 1. **or other beneficiary:**

First name

Surname

Name of Bank

IBAN

Swift- / BIC-Code

3. Travel details:

In any event, please submit copies of your travel confirmation and your insurance certificate or the insurance confirmation with proof that the premium has been paid (receipt)!

Destination

☐ Private travel ☐ Business travel

Commencement of journey / stay

End of journey / stay

Is accommodation available to you throughout the year at the destination? ☐ No ☐ Yes

4. Details on the costs incurred:

Please submit bills, receipts and medical prescriptions as originals and copies of any foreign exchange receipts or credit card statements!

In which currency were the bills paid?

Currency denomination

How were the bills paid? ☐ Cash payment ☐ Credit card (please enclose card statement)

Please list all the bills here – even if these have already been submitted:

Please use an additional sheet of paper if necessary

Doctor in charge or biller	Date of treatment	Total amount of bill (with currency denomination)

see reverse

5. Details of the course of the illness or the accident:

In case of an illness, please submit a copy of the medical report or report on the findings / diagnosis, in case of an accident, also a copy of the accident report (if any).

Please describe in your own words when and how the complaints began and progressed, in case of an accident, how the accident happened: Please use an additional sheet of paper if necessary.

When did the illness occur for the first time? Date | | . | | . | | | | at | | : | | o´clock

What was the doctor's diagnosis?

In-patient treatment at a hospital at the destination? ☐ No ☐ Yes from | | . | | . | | | | to | | . | | . | | | |

Hospital / Clinic (Name and address)

Name of the doctor referring patient for in-patient treatment (First name / Surname) Please enclose the discharge report of the hospital.

Was the in-patient treatment preceded by out-patient treatment (e.g. by the hotel doctor)? ☐ No ☐ Yes

Were you ever treated for this illness before this journey / your stay? ☐ No ☐ Yes

If yes, name and address of the doctor in charge

Which doctor treated you after you returned from your journey / your stay?

Name and address of the doctor in charge

Name and address of your family doctor

6. Additional information in case of an accident:

Place of accident

Date of accident | | . | | . | | | | at | | : | | o´clock

First name / Surname of accident perpetrator

Address of accident perpetrator

Were there any witnesses who saw the accident? ☐ No ☐ Yes

☐ Mr ☐ Ms First name / Surname 1st Witness

Address

☐ Mr ☐ Ms First name / Surname 2nd Witness

Address

Was the accident taken down by the police? Please enclose any police report. ☐ No ☐ Yes

If yes, name and place of the police station

Reference number

see reverse

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7. Details of other insurance contracts:

Which statutory health insurance scheme or private medical insurance are you a member of?

Name of the health insurance scheme / medical insurance

Membership number

Address of the health insurance scheme / medical insurance

Do you have any other health or repatriation insurance with international cover (e.g. via the statutory health insurance, a credit card or your membership in ADAC automobile club, Red Cross, etc.)?

☐ No ☐ Yes

If yes, name of the company / association

Membership or Credit card number

Address of the company / association

If you are covered by a statutory health insurance: Do you have a private additional insurance for in-patient treatment?

☐ No ☐ Yes

If yes, name of the private additional insurance company

Policy number

Address of the private additional insurance company

If you are covered by a statutory health insurance, please state the tariff you selected here if this differs from the standard tariff:

Have you filed any other application for reimbursement with a different office (e.g. statutory or private health insurance, benefits office etc.)?

▶ Please submit proof of reimbursement if applicable.

☐ No ☐ Yes

Do you have a private accident insurance?

☐ No ☐ Yes

If yes, name of the insurance company

Policy number

Address of the insurance company

8. Instructions on duty to tell the truth (Section 28 of the German Insurance Contract Act [VVG]):

▶ Please fill in completely if you are a member of a statutory health insurance in Germany!

The above details are true and have been given to the best of my knowledge. I have noted that intentionally false or incomplete details can result in a loss of insurance benefits. If false or incomplete details are provided through gross negligence, the insurance company can reduce the insurance benefits in proportion to the degree of fault. The insurance benefits will not be reduced if I can furnish proof that false or incomplete details were not provided through gross negligence. If I furnish proof that the intentional or grossly negligent details provided were not the cause of the determination of the insured event or the determination or the scope of the insurance company's liability for insurance benefits, the insurance company shall remain obliged to pay insurance benefits. The latter restriction shall not apply if the false or incomplete details were fraudulently provided by me. In case of fraudulently provided or incomplete details, the insurance company shall be released from its obligation to pay insurance benefits in all cases.

Place / Date

Signature (Minors require the signature of a parent or guardian)

▶ see reverse

Declaration of assignment

Please fill in completely if you are a member of a statutory health insurance in Germany!

I hereby assign

Please write your name in full.

☐ Mr ☐ Ms

First name(s)

Surname(s)

Street

Street Number

Postcode

Place

my claims against my statutory health insurance

Name of the health insurance

Insurance number

Address of the health insurance

relating to the illness / the accident

from

in (Destination / Place)

to AGA International S.A., Bahnhofstraße 16, D - 85609 Aschheim bei München.

Place / Date

Signature (Minors require the signature of a parent or guardian)

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