CareMed®
International Insurance

Medical Claim form

Your personal data	
Last name:	First name:
Date of birth (DD/MM/YY):	Gender:
Date of departure from home country*:	
*please add travel receipts for proof of departure, e.g. plane or train ticket or separate written statement	
Insurance period from to	Renewal period from to
Address in home country	**Address in country of destination**
Street:	c/o:
City, ZIP code:	Street:
State:	City, ZIP code:
Country:	State:
Phone number:	Country:
E-mail address:	Phone number:
Your medical treatment	
Type of illness or accident:	
Has this illness/accident occurred or has been treated prior to start of travel? yes ❑ no ❑ If yes, when?	
In case of an accident : own responsibility ❑ caused by a third party ❑	
Is there currently insurance cover through another health insurance provider (e.g. credit card)? If yes, which insurance?	
Number of enclosed documents:	
Reimbursement	
Payments are possible only by bank transfer.	
Have you already paid the doctor's bill? yes ❑ no ❑	
If no, payment will be made directly to the doctor/hospital:	
Name of attending doctor/hospital:	
Address of attending doctor/hospital:	
If yes, you will receive reimbursement by wire transfer to the below account:	
Account holder:	
Name of bank:	
Address & country of bank:	
SWIFT/BIC (please indicate in any case):	
IBAN (please indicate in any case):	

Claim documents		
Send completed and signed claim form as well as original invoices, documents and available medical reports to our claims office. INCOMPLETE OR WRONG INFORMATION MAY CAUSE A DELAY IN CLAIM PROCESSING.	**Contact claims office 1** for cases that occur in the USA MedCare International, Inc. 12480 West Atlantic Boulevard Suite 2 Coral Springs, FL 33071, USA Attention to Mrs Lacroix / Mrs Schmidt **Phone: 1-800 397 9905 (toll-free number)** **E-mail: CareMedClaims@hansemerkur.de**	**Contact claims office 2** HanseMerkur Reiseversicherung Abtlg. RLK 4/CareMed Claims Siegfried-Wedells-Platz 1 20354 Hamburg Germany **Phone: +49(0)40-4119-2671** **E-mail: CareMedClaims@hansemerkur.de**

I hereby authorize any hospital, physician or other person who has attended or examined me, including those in my home country to furnish to the Assistance Center, or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photostatic copy of this authorization shall be considered as effective and valid as the original.

Date	Signature of insured