

**Overseas Health Insurance Reimbursement Claim Form**

AW-  
 Policy number \_\_\_\_\_ | Tariff  AW24  AW-EH  AW-PLUS  AW24-RK  AW24-DR

**Information about the policyholder/the insured person**

Host organisation \_\_\_\_\_

Insured person's surname \_\_\_\_\_ | Forename \_\_\_\_\_ | Date of birth \_\_\_\_\_

Insured person's address: Street, house number \_\_\_\_\_ | Post code \_\_\_\_\_ | Town \_\_\_\_\_

Telephone number \_\_\_\_\_ | E-mail \_\_\_\_\_

**For the AW24, AW-EH, AW-PLUS and AW24-DR tariffs**

I hereby apply for the reimbursement of health costs which I have incurred. To this end I attach **original copies** of the following:

Type	Number	Amount	Currency
Medical invoice(s)			
Medication invoice(s)			
Hospital bill(s)			
Medical aid invoice(s)			
Other receipts			

**For the AW24-RK tariff**

I hereby apply for the reimbursement of the remaining costs after advance benefit paid by statutory insurance. The statement for the statutory health insurance is attached.

**I was treated for:**

Diagnosis \_\_\_\_\_

**Payment Information (Reimbursement to the following account)**

Please pay the reimbursement into the following Euro-account:

Account holder \_\_\_\_\_

IBAN \_\_\_\_\_ | BIC \_\_\_\_\_

Please pay the reimbursement into the following international account: (bank and/or conversion fees may incur)

Name and adress of the Account holder \_\_\_\_\_

Name and adress of the bank institute \_\_\_\_\_

Account currency \_\_\_\_\_ | Account No. \_\_\_\_\_ | Routing No. \_\_\_\_\_ | SWIFT/BIC \_\_\_\_\_

**Release from the duty of confidentiality**

I hereby release doctors who are treating or who have treated me, hospitals, insurance companies, authorities and other places from their duty of confidentiality and authorise DR-WALTER GmbH/Central Krankenversicherung AG to collect all necessary information to allow them to investigate their duty to provide benefit. I confirm this by signing below.

Place, date \_\_\_\_\_ | Signature \_\_\_\_\_