AIDWORKER

DR-WALTER

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

Please send to: DR-WALTER GmbH, Leistungsabteilung (Claims Department), Eisenerzstrasse 34, 53819 Neunkirchen-Seelscheid, Germany

For queries: T +49(0)2247 9194-31, leistung@dr-walter.com