

# Important Information Flyer:

Amendment to current Policy Terms and Conditions.

**ENGLISH :** The policyholder has by taking out this insurance policy given International Health Insurance danmark A/S its irrevocable consent to the transfer by International Health Insurance danmark a/s of the policy to Bupa Insurance Limited. The policyholder will receive separate notification from International Health Insurance danmark a/s in the event that International Health Insurance danmark a/s utilises this consent to the transfer of the insurance policy.

**ESPAÑOL:** El titular del seguro, al suscribirlo, le ha otorgado a International Health Insurance danmark a/s su consentimiento irrevocable para que International Health Insurance danmark a/s pueda -a su vez- cederle esta póliza de seguro a Bupa Insurance Limited. El titular del seguro recibirá una notificación por separado, por parte de International Health Insurance danmark a/s, en caso de que International Health Insurance danmark a/s haga uso de su consentimiento para la cesión de dicha póliza de seguro.

**DANSK:** Forsikringstager har ved sin tegning af denne forsikringspolice givet International Health Insurance danmark a/s sit uigenkaldelige samtykke til, at International Health Insurance danmark a/s kan overdrage denne forsikringspolice til Bupa Insurance Limited. Forsikringstager vil modtage særskilt underretning fra International Health Insurance danmark a/s, såfremt International Health Insurance danmark a/s udnytter dette samtykke til overdragelse af forsikringspolisen.

**FRANÇAIS :** En souscrivant cette police d'assurance, l'assuré a donné à International Health Insurance danmark a/s son consentement irrévocable quant au transfert par International Health Insurance danmark a/s de sa police à Bupa Insurance Limited. Dans le cas où International Health Insurance danmark a/s ferait usage de ce consentement pour transférer ladite police, l'assuré en serait informé personnellement par International Health Insurance danmark a/s.

**ITALIANO:** Stipulando la presente polizza di assicurazione il titolare ha dato alla International Health Insurance danmark a/s il suo consenso irrevocabile alla facoltà di cessione della polizza alla Bupa Insurance Limited. Nel caso in cui la International Health Insurance danmark a/s si avvallesse di detto consenso alla cessione della polizza di assicurazione, il titolare della polizza ne riceverà specifica comunicazione dalla International Health Insurance danmark a/s.

**NORSK :** Ved å skrive under på denne forsikringspolisen gir forsikringstakeren International Health Insurance danmark a/s sitt ujenkallelige samtykke til at International Health Insurance danmark a/s kan overdra denne forsikringspolisen til Bupa Insurance Limited. Forsikringstakeren vil underrettes spesielt fra International Health Insurance danmark a/s hvis International Health Insurance danmark a/s benytter dette samtykket til å overdra forsikringspolisen.

**PORTUGUÊS :** O tomador de seguro, ao subscrever esta apólice de seguro, outorgou à International Health Insurance danmark a/s o seu consentimento irrevogável para que a mesma transfira a apólice para a Bupa Insurance Limited. O tomador de seguro irá receber uma notificação em separado da parte da International Health Insurance danmark a/s caso a mesma utilize este consentimento para a transferência da referida apólice de seguro.

**SVENSKA :** Genom tecknande av denna försäkring ger försäkringstagaren International Health Insurance danmark a/s sitt oåterkalleliga samtycke till att International Health Insurance danmark a/s får överlåta denna försäkring till Bupa Insurance Limited. Försäkringstagaren meddelas särskilt av International Health Insurance danmark a/s om International Health Insurance danmark a/s väljer att utnyttja detta samtycke till överlåtelse av försäkringen.

**DEUTSCH :** Der Versicherungsnehmer gibt, indem er diese Versicherungspolice abschließt, der International Health Insurance danmark a/s seine unwiderrufliche Zustimmung zur Übertragung der Police durch die International Health Insurance danmark a/s an die Bupa Insurance Limited. Der Versicherungsnehmer empfängt eine gesonderte Benachrichtigung von der International Health Insurance danmark a/s, im Falle dass die International Health Insurance danmark a/s diese Zustimmung zur Übertragung der Versicherungspolice anwendet.

# Claim Form

(Please use block letters)

## Information about the insured

Travel period: From (day/month/year)	<input type="text"/>	To (day/month/year)	<input type="text"/>
First name(s)	<input type="text"/>	Date of birth (day/month/year)	<input type="text"/>
Family name(s)	<input type="text"/>	Sex (M/F)	<input type="text"/>
Address	<input type="text"/>		
City	<input type="text"/>	Postal Code	<input type="text"/>
Country	<input type="text"/>	Tel. daytime	<input type="text"/>
Tel. evening	<input type="text"/>	Fax	<input type="text"/>
E-mail	<input type="text"/>		
Reimbursement address (if different from above)	<input type="text"/>		
	<input type="text"/>		
Policy number	<input type="text"/>	<input type="text"/>	<input type="text"/>

## In case of illness / injury

Is this claim for:     Illness     Injury     Accident     Other

Where did the illness / injury occur?

Country     Date (day/month/year)

Diagnosis

Describe the course of the illness / injury (date of first symptom, etc.)

Have you previously had similar symptoms?     YES     NO    If YES, when?

Describe the symptoms

Name of your doctor in country of permanent residence

Address

City     Postal Code

Telephone     Fax

*A medical report must be included. If you need extra space in order to give a full description, please continue on a blank piece of paper.*

## In case of an accident

What happened? Describe the situation

*In case of an accident, a police report must be submitted.*

Names and addresses of witnesses, if any

**In case of treatment by a doctor**

Date(s) of treatment (day/month/year)

Doctor's name

Address

City  Postal Code

Telephone  Fax

E-mail

*Please enclose all information from the doctor together with the original and receipted bills.  
The bills must state the dates of treatment and specify each individual amount.*

**In case of treatment at a hospital or an emergency room**

Date(s) of treatment (day/month/year)

Date of discharge (day/month/year)

Hospital's name

Doctor's name

Address

City  Postal Code

Telephone  Fax

E-mail

*Please enclose all information from the hospital together with the original and receipted bills.  
The bills must state the dates of treatment and specify each individual amount.*

**Other insurance**

Do you have insurance cover with another company?  YES  NO

Name and address

Policy number

Has the claim been reported to the other company?  YES  NO

**Reimbursement**

*Please enclose the original itemised and receipted bills and travel documentation.*

The amount should be reimbursed to:  Policyholder  Other

Amount  Currency

 **Please transfer reimbursement to my credit card**

VISA  Eurocard / MasterCard  JCB

Card no.  Expiry date (month/year)

 **Please transfer reimbursement to my account**

Name of bank

Address

BIC / S.W.I.F.T. Code / ABA, if any

IBAN

Account no.

Account holder

*If no choice of reimbursement method has been made, IHI will send a cheque.  
Your choice of reimbursement method cannot be changed after the claim has been processed.*

**Must be signed by the insured**

I, the undersigned, declare that all information given in this Claim Form is in accordance with the truth and that nothing is concealed. I authorise International Health Insurance danmark a/s (the Company) to obtain information from any doctor, hospital or insurance company concerning myself or any co-insured person in order to process the claim in accordance with the Policy Conditions.

I hereby accept that the Company will record the information given for the purpose of processing data in connection with e.g. premium collection, processing of claims, reimbursements etc. In case of non acceptance of the request for reimbursement, the information given may be recorded. The Danish Act on Processing of Personal Data allows me the right of access to see documents and information recorded. I also accept that all correspondence concerning the insurance will be sent to the person registered as policyholder.

Date  Signature