

# Claim form

Policy nr.

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Please complete the following claim form and send it back by email to [claim-services@advigon.com](mailto:claim-services@advigon.com)  
*Instructions and address are at the second page*

## INSURED PERSON

<b>LAST NAME</b>	<b>First name</b>
<b>Gender</b> Male ( <input type="checkbox"/> )    Female ( <input type="checkbox"/> )	<b>Date of birth</b> (dd/MM/YYYY)
<b>Email</b>	<b>Phone number</b>
<b>Address</b>	<b>Zip / City</b>

## BANK ACCOUNT FOR REIMBURSEMENT (Attention: please fill in all the details carefully)

<b>Bank holder name + full bank address</b>	Same as insured person ( <input type="checkbox"/> )
<b>Bank name + full bank address</b>	<b>IBAN</b>
	<b>Swift / BIC</b>

**Are there any other insurers covering and/or reimbursing the costs for this claim?**      Yes (  )    No (  )

In the affirmative, please send us the coordinates of these insurers as well as the detailed accounts of any settlements already made and copies of medical prescriptions, invoices and other relevant supporting documents.

## ILLNESS

<b>Type of illness / Diagnostic</b>	<b>Date/time first symptom</b>
<b>Description</b>	

## ACCIDENT

<b>Date of the accident</b>	<b>Place of accident</b>
<b>Circumstances/Nature of the injury</b>	

## OTHERS

<b>Date of the event</b>	<b>Place of event</b>
<b>Circumstances/Nature of the event</b>	

## CONFIRMATION

I confirm that I attached all as indications below (all must be ticked to be reimbursed)

<input type="checkbox"/> Detailed invoice	<input type="checkbox"/> Proof of payment (bank, cash, credit card receipt)
<input type="checkbox"/> Physician prescription(s)	<input type="checkbox"/> Diagnostic of the illness, accident or maternity
<input type="checkbox"/> Bank holder and bank name complete details	<input type="checkbox"/> Claim form completed

By submitting your claim, you declare that you have answered and provided all questions and statements to the best of your knowledge, accurately and in accordance with the truth. This means that you have answered all questions honestly and have not withheld or concealed any information. If you have not done so, this may have consequences for your claim.

Date

Signature

### IMPORTANT INFORMATION

In order to get refunded as quickly as possible, send us all the necessary documents stated above. Each new event in case of sickness, accident, maternity needs a separate claim form.

Complete bank details are required. Bank name or holder without full address can block the transaction(s).

To avoid high bank fees, we suggest that you collect your invoices for reimbursement and send it together with the claim form to our claims management.

### ADDRESS FOR SENDING CLAIM FORM

By scan : [claim-services@advigon.com](mailto:claim-services@advigon.com)

By postal mail at the following correspondence address :

**Claims Department**  
Advigon Versicherung AG  
Claims-Services  
20911 Hamburg

(the company reserves the right to request originals)

In case of emergency, hospital admission or pre-approvals, please contact :

**Alarm Service 24/7 +49 (0) 621 5490-1906**