

Policy number: _____

Please note: if the following details are not listed on the invoice, please kindly inform about:

- 1) Diagnosis or description of the sickness (please not only "treatment");
- 2) The specification of individual treatments rendered and the dates and costs thereof;
- 3) In case of purchase of medicines in the pharmacy please add a copy of the medical prescription; for eyeglasses and contact lenses the strength in dioptries has to be listed for each glass and lens;
- 4) If these details are not in English language, please kindly translate by yourself;
- 5) Please be informed, that you can send the detailed invoices together with this claim form to claim@inter.de

No.	Family Name	First Name	Treatment Date	Diagnosis (such as name of illness/reason for treatment)	Currency	Amount of Bill
1	_____	_____	_____	_____	_____	_____
2	_____	_____	_____	_____	_____	_____
3	_____	_____	_____	_____	_____	_____
4	_____	_____	_____	_____	_____	_____
5	_____	_____	_____	_____	_____	_____
6	_____	_____	_____	_____	_____	_____
7	_____	_____	_____	_____	_____	_____
8	_____	_____	_____	_____	_____	_____
9	_____	_____	_____	_____	_____	_____
10	_____	_____	_____	_____	_____	_____

Name of account holder: _____

Phone: _____ e-mail: _____

IBAN (International Bank Account No.): _____ BIC (or Swift code): _____

_____ Date _____ Signature