CareMed®
International Travel Insurance

Claim Form

Your personal data:	
Name Date of birth (DD/MM/YY)	First name
Address in home country:	**Address in foreign country:**
I will return to my home country on (DD/MM/YY):	c/o
Street	Street
City ZIP code	City ZIP code
State	State
Country	Country
Phone number	Phone number
E-Mail address	E-Mail address
Your medical treatment:	
Type of illness or accident	
If illness, have you had it before? If yes, when? If yes, when?	
In case of an accident own responsibility ❑ caused by a third party ❑	
Reimbursement (the insured shall pay bank fees)	
Have you already paid the doctor's bill? yes ❑ no ❑	
If no, payment will be made directly to the doctor/hospital	
Name of attending doctor/hospital	
Address of attending doctor/hospital	
If yes, you will receive reimbursement by wire transfer to your account	
Name of bank	
Address & country of bank	
Name of account holder Account number Bank Code	
SWIFT/BIC and IBAN (please indicate in any case)	
Claim documents	
Send completed claim form with the original invoices to the claims office indicated below. **INCOMPLETE OR WRONG INFORMATION WILL CAUSE A PAYMENT DELAY.** CareMed Claims CISI Claims Department 1 High Ridge Park Stamford, CT 06905	I hereby authorize any hospital, physician or other person who has attended or examined me, including those in my home country to furnish to the Assistance Center, or its representative, any and all information with respect to any illness or injury, medical history, consultation, prescriptions or treatment, and copies of all hospital or medical reports. A photostatic copy of this authorization shall be considered as effective and valid as the original. Date Signature of insured