To
Care Concept AG
P.O. Box 30 02 62
53182 Bonn, Germany

Person insured: Surname, first name: D.O.B..:
Certificate of insurance number: (please quote in all correspondence)

In connection with registration of my indemnity claims, please find enclosed the following documents marked with a cross:

☐ Details of why I am asking for a refund of the costs incurred:
- e.g. date of falling ill / accident, type of illness, diagnoses - attach a separate sheet if necessary

_____

_____

☐ In the case of pregnancy: full copy of the pregnancy record

☐ In case of death: Copy of the death certificate

☐ Evidence of commencement of foreign stay (e.g. copy of immigration document, passport, ticket, etc.)

☐ Copies of documentary evidence of eligibility for insurance cover as required under terms and conditions (e.g. residence permit, au pair contract, etc.)

☐ In the case of foreign stay as an au pair, language student, etc. documentary evidence of course attendance

☐ Where a claim or claims have been registered with another insurer:
Most recent invoice letter from the other insurer with which claim(s) have been registered

☐ Original invoices as below:

Ser. No.:	**Issuer:**	**Invoice number:**	**Invoice date:**	**Amount:**	**Already paid on:**

(If more space is needed, please use the reverse side)

The potential insurance benefits should be paid to (payments may only be made by bank transfer):	
Sort code:	
Account number:	
Bank:	
BIC / SWIFT code:	
IBAN:	
Account holder:	

(Place, Date) (signature of the claimant or his/her legal representative)

Claims processing by
Care Concept AG
P.O. Box 30 02 62, 53182 Bonn, Germany
Phone.: + 49 228 97735-22 Fax: +49 228 97735-922 e-Mail: leistung@care-concept.de Internet: www.care-concept.de

Claims notification
Overseas medical insurance

To process the claim on behalf of the relevant insurer we need some further information. We therefore ask you to complete this form, sign it and send it back to us as soon as possible. Thank you!

Certificate of insurance number _____ **(please quote in all correspondence)**

1. Details of the individual affected

Title:	□ Herr □ Frau
Surname:	
First name:	
Current address:	Street:_____ Post code:_____ Town/city:_____ Country:
Full address of principal place of residence in home country:	Street:_____ Post code:_____Town/city:_____ Country:
e-Mail-Address:	
Nationality/nationalities:	
Tel.:	
Tel. (mobile/cell):	

2. Details of the foreign stay:

Commencement of stay:	(Please enclose a full copy of your passport, visa and other qualifying evidence such as copies of tickets, fuel receipts, etc.)			
Planned end of the stay:				
Country of stay:				
Reason for travel:	□ Language course / atudent (go to 2.1.)	□ Au pair (go to 2.2.)	□ professional work activity (go to 2.3.)	□ Other (go to 2.4.)

2.1. Foreign stay to attend language course / as a student

Main reason for the foreign stay:	
I have attended the following training courses:	(please enclose suitable evidence such as enrolment certificates, attendance certificates, etc.)

2.2. Foreign stay as an au pair

Main reason for the foreign stay:	
I have attended the following training courses as an au pair:	(please enclose suitable evidence such as attendance certificates, etc.)

2.3. Auslandsaufenthalt wegen beruflicher Tätigkeit

Reason for the foreign stay:		
Name and full address of employer:	_____	
The claims made relate to my professional work activity: (e.g. work accident, work-related illness, etc.)	□ no	□ yes

2.4. Foreign stay for other reasons:

Reason for the foreign stay:	

3. Information pertaining to the claim:

(Bitte reichen Sie die Arztrechnungen, Rezepte, Quittungen, ärztliche Verordnungen etc. im **Original** ein. Falls eine Vorleistung z.B. durch eine gesetzliche Krankenkasse oder einen anderen Kostenträger erfolgt, genügt auch eine Kopie mit einem Erstattungsvermerk. Bei einer stationären Behandlung fügen Sie bitte auch eine Kopie des Entlassungsberichtes bei.)

The medical treatment was carried out for	
Illness:	□ no □ yes (please go to 3.1.)
Dental treatment:	□ non □ yes (please go to 3.2.)
Accident:	□ no □ yes (please go to 3.3.)
Treatment for pregnancy:	□ no □ yes (please go to 3.4)
Screening examination:	□ no □ yes
Vaccination:	□ no □ yes

3.1. ärztliche Behandlung wegen Krankheit:

The treatment was carried out as a result of:	(please describe the health problems in your own words)
The complaints first occured on:	
The complaints were treated by: (please give details of name, address telephone number, fax number, e-mail address; if more space is required please attach a separate sheet)	1. 2. 3.
I was treated for the illness before the date of departure or it is the of an illness treated prior to the date of departure or the result of an accident suffered prior to the date of departure:	□ no □ ja Yes (please state diagnoses and treatment dates together with names nd addresses of attending physicians; if more space is required please attach separate sheet):
Who is or was your general practitioner or specialist doctor in the last 12 months prior to commencement of your foreign stay: (please give details of name, address telephone number, fax number e-mail address; if more space is required please attach a separate sheet)	1. 2. 3.
Did you have complaints, illness or infirmity prior to the beginning of the foreign stay for which no medical treatment was obtained:	□ no □ Yes (please state diagnoses and treatment dates together with names and addresses of attending physicians; if more space is required please attach a separate sheet):

3.2. Medical dental treatment:

The treatment was carried out as a result of:	(please describe the health problems in your own words)
The complaints first occured on:	
The complaints were treated by: (please give details of name, address telephone number, fax number, e-mail address; if more space is required please attach a separate sheet)	1. 2. 3.

I received treatment prior to departure for the problems on the same tooth/teeth:	□ no □ Yes (please state diagnoses and treatment dates together with names nd addresses of attending physicians; if more space is required please ttach a separate sheet):
Who is or was your general practitioner or specialist doctor in the last 12 months prior to commencement of your foreign stay: (please give details of name, address, telephone number, fax number; E-Mail address if more space is required please attach a separate sheet)	1. 2. 3.
Did you have tooth complaints prior to commencement of the foreign stay which were not medically treated:	□ non □ Yes (please state diagnoses and treatment dates together with names nd addresses of attending physicians; if more space is required please ttach a separate sheet):

3.3. Behandlung wegen der Folgen eines Unfalls

Details of the accident		
Date of damage/loss:		
Time:		
Where the damage/loss occured:		
Details recorded by police: □ yes □ no	Office/station: Address: File reference:	
Outline description / sketch: (please also enclose any photos)		
Details where accident was caused by a third party		
Full address of person responsible for accident:	StrEeT: Zip code (post code): House number: Town/city: Country:	
Claims have been lodged:	□ no, because	□ yes, with
Further details/information:		
Nature and extent of injury:	Nature (for example, bruising):	Extent (e.g. whole body):
Inpatient treatment:	□ no	□ yes, from: to

Attending physician:	Initial treatment was undertaken by: Name:_____ Address:_____ _____ Tel.:	Subsequent treatment was undertaken by: Name:_____ Address:_____ _____ Tel.:
Reported to a Statutory Institute for Work Accident Insurance & Prevention:	□ no, because _____	□ yes, to (name):_____ Address:_____ _____ File reference:

3.4. Treatment for pregnancy:

The pregnancy was ascertained on:	
The pregnancy was ascertained in week:	(please enclose a full copy of the pregnancy record)
The treatment was carried out as a result of:	□ screening / check-up □ complaints / premature labour □ premature birth □ delivery
The first symptoms appeared:	
Initial medical treatment was undertaken by:	
Please name all physicians attending in relation to your pregnancy: ((please give details of name, address, telephone number, fax number; E-Mail address if more space is required please attach a separate sheet))	1. _____ 2. _____ 3.

4. Ergänzende Angaben bei Todesfall:

Date of death:	
Cause of death: (please enclose a copy of the death certificate)	

5. Details of other insurance policies::

Additional insurance cover is in place for foreign stays: (e.g. via a credit card such as EuroCard or VISA; AmEx) via a membership (ADAC, ASB, DRK or other association offering rescue benefits)	□ no	□ yes, to (please state membership number / credit card number and name of bank or rescue service)
Additional health insurance cover is in place from a public sector health insurance fund, a private health fund (including supplementary insurance cover)	□ no	□ yes, to (please give name. address and policy number)
The documents submitted have also been submitted to another insurance company:	□ no	□ yes, to (please give name. address and enclose most recent (invoice) letter)

6. Payment terms

The insurance benefit which may be payable should be paid to: (payments may only be made by bank transfer)	
Sort code:	
Account number:	
Bank:	
BIC / SWIFT code	
IBAN	
Account holder	

Important notes on the consequences of breaches of obligations following the claims event:

Cautionary guidance pursuant to Sect. 28 IV of the German Insurance Policies Act (VVG)

Dear customer,

once the claims event has occurred, we need your help:

Duty to provide information and clarification

On the basis of the matters of contractual agreement reached with you, the Insurer, represented by Care Concept AG, may require you to provide any and every item of information that is necessary in order to verify the claims event or the extent of its obligation to provide insurance benefits (duty to provide information) and, by means of providing all detail helpful towards clarifying the facts of the matter (duty to provide clarification), to enable it to examine its obligation to provide insurance benefits. The Insurer may also require you to provide it with evidence / documents where this may be reasonably demanded of you.

No obligation to provide insurance benefits
Where, contrary to the matters of contractual agreement, you wilfully provide false account or no account whatsoever or where you wilfully fail to provide the Insurer, represented by Care Concept AG, with the required evidence / documents, you will not forfeit your entire claim, but the Insurer may curtail its insurance benefits in keeping with the gravity of such failing on your part. No curtailment shall occur where you provide evidence to the effect that you have not violated the obligation through gross negligence.

Despite breach of your obligations to provide information or clarification or to procure evidence / documents, the Insurer shall nonetheless remain obliged to provide insurance benefits to the extent that you provide evidence to the effect that the wilful or grossly negligent breach of obligation was not causal either to ascertainment of the claims event or to the extent of the obligation to provide insurance benefits.

Where you are in fraudulent breach of your obligations to provide information or clarification or to procure evidence / documents, the Insurer shall in all cases be free of any obligation to provide insurance benefits.

End of cautionary guidance

N.B.:
Where the right to contractual benefits is the entitlement not of you, but of a third party, such third party shall likewise be obliged to provide information and clarification and to procure documentary evidence.

Final declarations:

I confirm that my above statements are truthful and complete. I am aware that incorrect and / or incomplete information may result in loss of insurance cover. I have taken note of the above statements pursuant to Sect. 28 Para. 4 of VVG regarding the consequences of breaches of obligations following occurrence of the claims event.

I am aware that I am also responsible for the accuracy and completeness of details provided by me even where I have not completed this form personally.

I assign to the Insurer providing insurance cover my claims and entitlements, to the value of the benefits provided by such Insurer, against any party causing the accident / liable party / other party under an obligation to provide insurance benefits.

(Place, date) (Signature of policyholder) and (Signature insured person or his/her legal representative)

Consent to the collection, storage and use of personal data and medical data

1. Collection, storage, use and disclosure of personal data

I hereby give my consent that the insurer providing the cover (hereinafter referred to as "Insurer") and the administrator Care Concept AG (hereinafter "Care Concept") may collect, store, use and transfer between them personal data pertaining to me to such extent as may be required for purposes of checking the application and of establishing, executing or terminating the insurance policies and of invoicing commission payments.

2. Collection, storage and use of medical data

In order to be allowed to collect and use your medical data for this benefit application and in connection with the policy, the Insurer and Care Concept require your consent under data protection legislation and your confidentiality waivers in order to be able to collect your medical data from holders, such as doctors, who are under a duty of confidentiality, and in order - where necessary - to pass your medical data and other data falling under the protection of Sect. 203 of the German Penal Code to other recipients. The following statements of consent and confidentiality waiver are indispensable for purposes of checking the application and for establishment, execution or termination of your insurance policy. If you choose not to make them, it will generally not be possible to set up the policy.

I hereby give my consent that the Insurer and Care Concept may collect, store, use and transfer between them medical data disclosed by me in this claim notification and at any time in the future to such extent as may be necessary for purposes of checking the application and of establishing, executing or terminating this insurance policy.

3. Disclosure of your medical data to entities not pertaining to the Insurer

The Insurer shall subject downstream entities to a contractual duty to observe data protection and data security regulations.

3.1 Disclosure of data for medical assessment purposes

Where medical assessors have to be brought in for purposes of assessing the risks to be insured and of examining the obligation to provide benefits, the Insurer and Care Concept require your consent and confidentiality waiver where this involves disclosure of your medical data and other data subject to protection under Sect. 203 of the German Penal Code. You will be informed of each instance in which data is passed on.

I hereby give my consent that the Insurer and Care Concept, in its administrative capacity, may pass on my medical data to medical assessors where necessary for risk assessment purposes or for purposes of examining the obligation to provide benefits and where my medical data are used by such recipient(s) in accordance with the intended purpose and where the outcomes are passed back to the relevant Insurer. With regard to my medical data and other data protected under Sect. 203 of the German Penal Code, I hereby release persons working for Care Concept and the Insurer providing cover and also the assessors from their duties of confidentiality.

3.2 Disclosure of data where functions as assigned to other entities

Certain tasks, such as claims processing, telephone customer service and the emergency hotline, which may involve collection, processing or use of your data, are not handled by the Insurer and Care Concept in-house, but are rather assigned to other entities. Where your data falling under the protection of Sect. 203 of the German Penal Code is passed on, Care Concept and the Insurer providing cover require a confidentiality waiver from you for these entities.

I hereby give my consent that the Insurer and Care Concept may pass my medical data to

- Roland Assistance GmbH, Cologne
- MedCare International Inc. Coral Springs, Florida, USA

and that the medical data will be collected, processed and used there for the stated purposes to the same extent as the Insurer and Care Concept would be permitted so to do. To the extent necessary, I hereby release the staff of the Insurer and of Care Concept and of other entities from their duties of confidentiality with respect to disclosure of medical data and other data subject to the protection of Sect. 203 of the German Penal Code. The list does not purport to be exhaustive as changes may have occurred in the meantime. A current list may be obtained by written request to Care Concept.

3.3. Disclosure of data to reinsurers

In order to safeguard the meeting of your claims and entitlements, the Insurer and Care Concept avail themselves of reinsurance arrangements which assume the risk either in part or in whole. Information concerning your existing policies may be disclosed to reinsurers for purposes of settling commission payments and benefit payouts and for purposes of invoicing reinsurance arrangements and also in connection with risk and claims assessment. Your personal data will be used by the reinsurers for the aforementioned purposes only. You will be informed by the Insurer and by Care Concept regarding disclosure of your medical data to reinsurers.

I hereby give my consent to disclosure of my medical data - where necessary - to reinsurers and to their use thereof for the purposes mentioned. To the extent necessary, I hereby release the staff acting for the Insurer and for Care Concept from their duties of confidentiality with respect to the medical data and other data subject to the protection of Sect. 203 of the German Penal Code.

_____ _____

(Place and date (signature of the claimant or his/her legal representative)

Claims processing by
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