Claim form - Expatriate

Illness / injury

In case of illness / injury the following documents must be attached:

- Original documentation of the claim for compensation e.g. physician's statement and medical invoices
- If you have been in contact with the alarm center, please add your case number from the alarm center here:

Please fill in all fields. As soon as we receive all relevant information, we can start processing your claim. Not before.

1. Your insurance information

Company:	Policy number: Expatriate short term ☐ Expatriate long term ☐	
	If the illness/injury happened on a business trip / holiday , please fill out Departure date: _____ / _____ yr _____ Return date: _____/ _____ yr _____ Travel destination: _____	
Your name:	Your social security number/date of birth:	
Your Address:	Zip code/postal code:	City:
Country:	Your Tel. work/ private:	Your e-mail:

2. Who is the claim concerning?

Myself ☐ Other person ☐

If the claim concerns another person, please fill out these fields:

Your relation to the sick / injured person:

His/ her name:	His / her social security number/date of birth:	
Address (if not same as yours):	Zip code/postal code:	City:
Country:	Tel. work/ private:	E-mail:

3. Please state the nature of the claim

Illness / injury ☐	Health check/ vaccination ☐	Medical escort ☐	Accident ☐
Curtailment ☐	Dental illness / check-up ☐	Summoning ☐	Pregnancy ☐

4. Medical information

Date and time of illness/injury: _____ / _____ yr _____ at (0-24) _____ o'clock	
Date and time of first medical visit: _____ / _____ yr _____ at (0-24) _____ o'clock	
Date and time of hospitalization, if any: _____ / _____ yr _____ at (0-24) _____ o'clock Hospitalized from (date) _____ / _____ yr _____ to (date) _____ / _____ yr _____	
Have you experienced similar symptoms before your expatriation? Yes ☐ No ☐	
If yes, when?	Name and contact information of your treating doctor at the time:
Is it a chronic disease that was present at the time of expatriation? Yes ☐ No ☐	

5. **About the incident. Please give a detailed description of the incident**

6. **Expenses** (**please remember to enclose documentation for each expense. Thank you**)

Diagnosis	Nature of the expense (doctor, medicine, etc.)	Currency	Amount
	Total amount		

Please choose currency for reimbursement: DKK

7. **Your bank information** (the bank account to which you would like us to transfer the compensation)

Danish bank account ☐ Name of bank: Reg. No.: __ __ __ __ Account No.: __ __ __ __ __ __ __ __ __ __ Exact name of bank account holder: _____
International bank account ☐ Country: _____ Name of bank: SWIFT/BIC: _____ IBAN: _____ Exact name of bank account holder: _____

8. Other insurance

Have you taken out local insurance? Yes ☐ No ☐ If yes, which insurance company: _____ and your policy number _____		
Are you an active member of "Sygeforsikringen Danmark" ? Yes ☐ No ☐		
Do you have a credit card that includes travel insurance? Yes ☐ No ☐	If yes, please state type of credit card: _____ Name of issuing bank: _____	Card number (first 6 digits and last 4 digits): __ __ __ __ __ __ XXXXXX __ __ __ __
Has the claim been reported to the credit card or local insurance? Yes ☐ No ☐		

9. Declaration of content

The undersigned solemnly declare that the above information is true. I hereby authorize AIG to procure the necessary records / information for the assessment of the incident and questions connected to the incident. I also allow that these records /information be sent to other companies that are to pay compensation in relation to the claim. If the claim has been reported to the national Board of Industrial injuries or to the police, I allow the companies to collect information therefrom.

Date:	Signature:

Please send this claim to: Please save to your computer before clicking "submit". Thank you.

travelclaim@aig.com or **Submit to AIG**

or

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