

Application for Voluntary Coverage
-Through VICTORIA Health Insurance-

Please fill out and return to Fulbright Commission
 Oranienburger Str. 13-14, 10178 Berlin, fax: +49-30-28 4443-773, email: americanprograms@fulbright.de

German address:

Grantee:

name: _____
birthday: _____

Street: _____
Area Code / City: _____
Phone (private): _____

Coverage extension:

from: _____ **to:** _____

number of days: _____

I hereby request health insurance coverage through the Commission's Victoria-plan for a period outside my actual grant period (or as a travel grant recipient) and agree to pay the premiums promptly and directly to the Fulbright Commission. My request is optional.

Premiums: depend on age and duration of coverage, per person

- Under 30 yrs of age:** Euro 1.38 per day
- Child up to 14:** Euro 1.38 per day (up to 14th birthday)
- Over 30 yrs of age:** Euro 2.05 per day

Voluntary coverage is requested for:

(Please calculate your particular premium(s) by multiplying the number of calendar days by the age-related premium, and compute the total premiums if several persons are registered).

last name	first name	relation-ship	gender	birthday	coverage extension from:	to:	number of days	amount of premiums

Please make a bank transfer (Banküberweisung) in the total amount to:

Fulbright Commission
 Dresdner Bank/Commerzbank
 BLZ: 12 08 00 00
 Kto: 41 00 00 07 00

within 10 days of the requested inception date. Under „Verwendungszweck“ on the transfer form write: Voluntary Health insurance coverage and your name (write clearly please).

For questions, please contact the Fulbright Commission

Signature

Date

If you send this electronically your signature on the Fulbright grant document will cover this signature also.