

# REPAYMENT FORM

VICTORIA Krankenversicherung AG  
Department LGR7D  
Post office

40198 Düsseldorf

**Insurance number:** AR50 000 168.....

**Policy holder:** Fulbright

**Name of insured** .....  
(Name, first name) Date of birth

male .....  
 female .....  
(Address/Telephone)

I hereby request the repayment of the costs I have incurred due to illness. For this purpose I/we am/are enclosing the following (number of)

- ..... Doctor's invoice(s)
- ..... Pharmaceutical invoice(s)
- ..... Hospital invoice(s)
- ..... Medical aid/remedy invoice(s)
- ..... other cost receipts

**I was treated for:** ..... (Diagnosis)

I request repayment into my following account:

Account owner .....  
Account No. ....  
BLZ .....  
Bank .....

I hereby release doctors who are treating me, respectively have treated me, hospitals, as well as insurance companies, authorities and other offices from their professional secrecy and give VICTORIA Krankenversicherung AG authority to gather all necessary information to check their obligation of rendering service.

I confirm this with my following signature.

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature

