CLAIM FORM

(medical insurance)

For medical expenses exceeding 45 euros

- Name of Cardholder:______________________________
- Cardholder Number:______________________________
- Date of illness or accident:______________________________
- Description of illness or accident:

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- Indicate whether you expect to incur further expenses as a result of this illness or accident:

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- List of expenses:

DESCRIPTION	***AMOUNT***
TOTAL	

- I request the above ammount to be sent to the following address and person:

Date:____________________ Signature:____________________

Send this claim form to:

Marsh, S.A. (Att. Paloma Zamarriego)
Pº de la Castellana, 216
28046 - MADRID

With a maximun of two weeks from the date of the illness or accident.
Please provide us with the original invoices and medical prescription.

MARSH