

Corporate Travel Claim Submission

Submit your claim regarding any incident occurred during your business travel

Data Processing Consent

- I explicitly consent to the processing of my personal health data by Foyer Global Health S.A. and its services providers, including group companies, as set out in the Privacy Policy, for the purposes of providing health insurance cover and for the provision of related assistance services and support.

This consent may be revoked at any time.

[View privacy policy](#)

Employee Identification

Please fill in the information of the employee (main insured member), insured under this policy.

First name	<input type="text"/>	Last name	<input type="text"/>
Group Policy Number	<input type="text"/>	Employee ID	<input type="text"/>
Mobile prefix	<input type="text"/>	Mobile phone	<input type="text"/>
Corporate E-mail	<input type="text"/>		

Detail about the employee

Please complete the information of the employee

Male Female

Date of birth	<input type="text"/>	Street	<input type="text"/>
Building name/number	<input type="text"/>	Postal code	<input type="text"/>
City	<input type="text"/>	Country	<input type="text"/>
Nationality	<input type="text"/>		

Dependents

If you are claiming for one or more dependents who traveled with you, please add them here:

Detail about the insured person 1

Please complete the information of the insured person

Male Female Title

First name

Date of birth

Building name/number

City

Nationality

Dependency

Last name

Street

Postal code

Country

Detail about the insured person 2

Please complete the information of the insured person

Male Female Title

First name

Date of birth

Building name/number

City

Nationality

Dependency

Last name

Street

Postal code

Country

Detail about the insured person 3

Please complete the information of the insured person

Male Female Title

First name

Date of birth

Building name/number

City

Nationality

Dependency

Last name

Street

Postal code

Country

Detail about the insured person 4

Please complete the information of the insured person

<input type="radio"/> Male <input type="radio"/> Female	Title	<input type="text"/>	Dependency	<input type="text"/>
First name	<input type="text"/>		Last name	<input type="text"/>
Date of birth	<input type="text"/>		Street	<input type="text"/>
Building name/number	<input type="text"/>		Postal code	<input type="text"/>
City	<input type="text"/>		Country	<input type="text"/>
Nationality	<input type="text"/>			

Detail about the insured person 5

Please complete the information of the insured person

<input type="radio"/> Male <input type="radio"/> Female	Title	<input type="text"/>	Dependency	<input type="text"/>
First name	<input type="text"/>		Last name	<input type="text"/>
Date of birth	<input type="text"/>		Street	<input type="text"/>
Building name/number	<input type="text"/>		Postal code	<input type="text"/>
City	<input type="text"/>		Country	<input type="text"/>
Nationality	<input type="text"/>			

Travel

Please complete travel data

Detail about insured travel

Please fill in the information of your business trip

Start date	<input type="text"/>	End date	<input type="text"/>
Country	<input type="text"/>		
Travel type	<input type="checkbox"/> Air <input type="checkbox"/> Sea <input type="checkbox"/> Rail <input type="checkbox"/> Bus <input type="checkbox"/> Car		

Claim

Please add your claim

What would you like to claim?

Please fill in the information of the event you want to claim for

Member	<input type="text"/>	Claime Type	<input type="text" value="(Choose claim type)"/>
Event date	<input type="text"/>	Event Country	<input type="text"/>
Amount	<input type="text"/>	Currency	<input type="text" value="(Choose currency)"/>

Are you also insured somewhere else for this business trip?

- No additional coverage Yes, I have an insurance Yes, I have a social security coverage
- Yes, I may be covered by credit card Yes, I have other coverages

Bank account

Please complete bank account data

Detail about reimbursement account

Please fill in the information of your bank account for reimbursement

Name of the account holder	<input type="text"/>	Country	<input type="text"/>
Account number - IBAN	<input type="text"/>	Swift Code (BIC)	<input type="text"/>
		Currency	<input type="text" value="(Choose c"/>

Place, date:

Signature: _____