# PRIVATE HEALTH INSURANCE
# FORM OF EXPENSE NOTICE

AKSigorta
Bambaşka.

| | | | |
|---|---|---|---|
| Insurance Nr. | | Insured's Name - Surname | |
| Identification Nr. | | Name of Branch | |
| Policy Nr. | | Name of Group | |
| Register Nr. | | Name of Department | |

| **Inpatient Treatment Coverage** | **Account of Invoice** | **Payment Amount** |
|---|---|---|
| Hospital Services (surgery-hospitalization-small surgical intervention) | | |
| | | |
| | | |

| **Outpatient Treatment Coverage** | **Account of Invoice** | **Payment Amount** |
|---|---|---|
| Medical Examination | | |
| | | |
| | | |
| Medicine | | |
| | | |
| | | |
| Diagnostic Procedures | | |
| | | |
| | | |
| Physical Treatment | | |

| **Birth Control** | **Account of Invoice** | **Payment Amount** |
|---|---|---|
| Delivery - Caeserean - Section | | |
| Routine Diagnostic Tests / Examinations etc | | |
| Others | | |
| | | |
| | | |
| | **Aggregate** | |

I am ..... who signed below

I declared and accept that .....TL.....Kr. that written above was paid cash and completely in accordance with corporate health insurance policy's terms and limits to me/person who signed below or to registered account number in your company by Aksigorta A.Ş.

With present payment, the damage in question completely indemnify and I declared, accept and confess that I released Aksigorta A.Ş. embezzlement unconditionally due to medical expenses and I assigned the right to recourse to Aksigorta A.Ş. against third person who responsible to indemnify the damage that signified above.

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Indemnitee:
Name-Surname:
Account Number:
(Fill this area, if you didn'd inform account number before or if you want to change the account number.)

Sign

Date : ...../...../20.....



Barbaros Mah. Ihlamur Bulvarı No: 3B/228 Ataşehir/İstanbul Tel: +90 216 280 88 88 Faks: +90 216 280 88 00 MERSİS No: 0035000302200016
HİZMET MERKEZİ : 444 27 27 www.aksigorta.com.tr
mim@sencard.com.tr