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.

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.....

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