



Request for claim payments to be credited directly to bank account

PLEASE FILL IN ALL DETAILS AND USE BLOCK CAPITALS THROUGHOUT

This form is to be sent to: Atlas Healthcare Insurance Agency Limited, Abate Rigord Street, Ta' Xbiex XBX1121, Malta

Policy Details

| | |
|-------------------------|-----------------------|
| Policy No. | Group (if applicable) |
| Member name and surname | |
| ID Card/Passport No. | Mobile No. |
| Email Address* | Telephone No. |

*This is required for payment notification purposes

Bank Details

Note: Claim settlement by direct credit transfer is only possible for bank accounts which are within the Single Euro Payments Area (SEPA)

| | |
|--|----------------------|
| Bank Name | Branch |
| Name of Bank Account Holder | |
| IBAN (International Bank Account Number) | |
| <input type="text"/> | |
| BIC/SWIFT (Bank Identifier Code, foreign bank accounts only) | <input type="text"/> |

| | |
|--------------------|------|
| Member's Signature | Date |
|--------------------|------|

In future, if you are the subscriber, claims for all members aged under 18 will be credited to this account unless notified otherwise. If dependents aged 18 and over would like their claims to be settled to this account, please complete the section below.

Dependants (For completion ONLY for family members aged 18 and over)

| | |
|------------------------------|------|
| Dependant 1 name and surname | |
| Dependant's signature | Date |
| Dependant 2 name and surname | |
| Dependant's signature | Date |
| Dependant 3 name and surname | |
| Dependant's signature | Date |