

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 thatTL.....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 Acıbadem Sağlık ve Hayat Sigorta A.Ş.

With present payment, the damage in question completely indemnify and I declared, accept and confess that I released Acıbadem Sağlık ve Hayat Sigorta A.Ş. embezzlement unconditionally due to medical expenses and I assigned the right to recourse to Acıbadem Sağlık ve Hayat Sigorta 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.....