

TO THE ATTENTION OF THE

« MUTUELLE DE L’ALEBA »

B. P. 325

L-2013 Luxembourg

**COMPENSATION REQUEST**

**(ILLNESS / ACCIDENT / HOSPITALIZATION / DENTAL CARE)**

MUTUELLE ALEBA DEMANDE REMBT FONDS SOCIAL 7.7.2022 ANGL-FR-ALL

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Last and first name | | | |  | | | |
| Social security number | | | | |  | | |
| Street and number | | | |  | | | |
| Postal Code | |  | | | | Locality |  |
| Tel. |  | | | | | E-Mail |  |
| Employer | | |  | | | | |
| IBAN account | | |  | | | | |
| BIC code | | |  | | | | |

|  |  |  |
| --- | --- | --- |
| CMCM Member |  |  |
| Other complementary insurance |  |  |
| Name and address of your complementary insurance | | |
|  | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | |
| (City) | | (Date) | |
|  | |
| (Signature) | |



AU FONDS SOCIAL DE LA MUTUELLE DE L’ALEBA

B. P. 325

L-2013 Luxembourg

**DEMANDE DE REMBOURSEMENT**

**(MALADIE / ACCIDENT / HOSPITALISATION / FRAIS DENTAIRES)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Nom et prénom | | | | |  | | | |
| Matricule sécurité sociale | | | | | |  | | |
| Rue et N° | |  | | | | | | |
| Code postal | | |  | | | | Localité |  |
| Tél. |  | | | | | | E-Mail |  |
| Employeur | | | |  | | | | |
| Compte IBAN | | | |  | | | | |
| Code BIC | | | |  | | | | |

|  |  |  |
| --- | --- | --- |
| Membre de la CMCM |  |  |
| Autre assurance complémentaire |  |  |
| Nom et adresse de votre assurance complémentaire | | |
|  | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | |
| (Localité) | | (Date) | |
|  | |
| (Signature) | |



AN DEN SOZIALFONDS DER

« MUTUELLE DE L’ALEBA »

B. P. 325

L-2013 Luxembourg

**ERSTATTUNGSANTRAG**

**(KRANKHEIT/UNFALL / KRANKENHAUSAUFENTHALT / ZAHNVERSORGUNG)**

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Name und Vorname | | | | |  | | | |
| Sozialversicherungsnummer | | | | | |  | | |
| Strasse / Nr | | |  | | | | | |
| Postleitzahl | |  | | | | | Ortschaft |  |
| Tel. |  | | | | | | E-Mail |  |
| Arbeitgeber | | | |  | | | | |
| IBAN Konto | | | |  | | | | |
| BIC Code | | | |  | | | | |

|  |  |  |
| --- | --- | --- |
| Mitglied der CMCM |  |  |
| Andere Zusatzversicherung |  |  |
| Name und Adresse Ihrer Zusatzversicherung | | |
|  | | |
|  | | |

|  |  |  |  |
| --- | --- | --- | --- |
|  |  |  | |
| (Ortschaft) | | (Datum) | |
|  | |
| (Unterschrift) | |