I would like to receive a copy of the invoice in the future.

In the future, I would like to receive a copy of invoices that are sent directly to my health insurance provider automatically by mail to my address. I myself am responsible for the sensitive handling with information of invoice copies sent to this address.

◯ Ms ◯ Mr

Date of birth

First name

Surname

Street, n°

Postal code, town

Location, date

Signature

Print form