MEDICAL FEE
REIMBURSEMENT FORM

Please complete in block capitals.

Full Name

Date of Birth (dd/mm/yyyy)

Plan number (if known)

This is to confirm that I have paid for the medical examination and tests required in relation to my recent application to RL360. I would like to request reimbursement of these fees to the bank account details below. I have attached a copy of the invoice and receipt of payment to support this request.

Bank account holders name

Bank account number

IBAN number

Bank sort code

SWIFT code

Route number (if applicable)

Bank name

Full bank address

Fee paid (including currency)

Please note that we are only able to make reimbursements in either US Dollars or GB Pounds. Please indicate your preferred choice of currency:

☐ USD ☐ GBP

Signed

Date (dd/mm/yyyy)

Privacy policy

Our full privacy policy can be viewed at www.rl360.com/privacy or can be obtained by requesting a copy from our Data Protection Officer.

RL360