Claim Form Cancellation

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Please complete the form in full, using block capitals, and send it to us by post, fax or e-mail.
In case you booked a **Seminar, Conference or Event Ticket cancellation insurance** please refer to all questions with reference "travel/journey" accordingly with Seminar, Conference or Event.

Policy or credit card no. _____ Claim No._____
(this is assigned by the Europäische!)

A. Information on the trip

Booking agency (e.g. travel agent) _____ Travel destination _____
booked on _____ Departure date _____ Return date _____
Insurance taken out on _____ Purpose of trip ☐ private ☐ business ☐ other _____
When was the trip ☐ cancelled ☐ rebooked ☐ interrupted _____
Travel price € _____
Cancellation costs € _____ representing _____ % of the travel price
Contact person for questions as may arise: Office stamp/Signature booking agency (e.g. travel agent)

Name _____
Phone _____ Date _____

B. Information on the traveller

☐ Mr. ☐ Mrs. First name _____ Last name _____
Street _____
Postal code _____ City _____ Country _____
Date of birth _____ Phone _____ E-mail _____

Other travellers who also cancelled/rebooked/interrupted their trip

First and last name	Date of birth	Family relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Why was the trip cancelled/rebooked/interrupted? ☐ Illness ☐ Death ☐ Pregnancy ☐ Other_____
☐ Accident: Was the accident caused (in part) by third parties? ☐ No ☐ Yes (enclose accident report – name/address of other party involved)
Name of the affected person _____
If family member who is not a co-traveller: Family relationship with the travellers _____
When did the event occur which led to cancellation/rebooking/interruption? _____
Hospital stay ☐ No ☐ Yes – from _____ to _____
Reported sick to your national health service provider ☐ No ☐ Yes – from _____ to _____
Do you own any **other cancellation insurance** or a **credit card**? ☐ No ☐ Yes – which?
Insurer _____ Policy No. _____
☐ Visa ☐ MasterCard ☐ DinersClub ☐ AmericanExpress ☐ _____ Card No. | | | | | | | | | x | x | x | x | x | x | x |
☐ Visa ☐ MasterCard ☐ DinersClub ☐ AmericanExpress ☐ _____ Card No. | | | | | | | | | x | x | x | x | x | x | x |
Card holder _____
Have compensation claims been made to other insurance companies, and have any compensation payments been made?
☐ No ☐ Yes – Insurer _____ Amount € _____

For the prompt processing of your claim, please enclose the following documents:

- Proof of insurance
- Booking confirmation and cancellation costs invoice (for flight bookings also refund receipts)
- In case of illness/accident/pregnancy: have the medical certificate on the following page made out in the event of cancellation/rebooking; in case of interruption include a medical certificate by the doctor treating on site (incl. diagnosis)
- Other reasons for cancellation have to be verified by relevant documents (e.g. conscription order, divorce suit, school leaving certificate, death certificate)
- If a family member who is not a co-traveller is affected, enclose proof of family relationship in addition (birth certificate etc.)
- Original unused travel documents (e.g. admission tickets)

I request that insurance benefits be deposited to ☐ a traveller ☐ the booking agency (e.g. travel agent)
on the following account: Account holder _____

IBAN _____ SWIFT/BIC _____

With my signature, I hereby confirm the accuracy and completeness of the information I have provided above. I hereby release the physician from doctor-patient confidentiality obligations and expressly allow my information to be shared with my insurer.

Date _____ Signature_____

Policy or credit card no. _____ Claim No._____
(this is assigned by the Europäische!)

C. Certificate of the attending physician (to the specialist, if treatment by a specialist proved necessary, or for the hospital in the event of hospital treatment – in case of mental illness confirmation has to be provided by a psychiatric specialist)

Dear Sir/Madam,

Due to the illness/accident/pregnancy of your patient, a claim against a cancellation insurance policy has been submitted to us. In the interests of processing this insurance claim as per our obligations, we request that you answer the questions below as fully as possible. Thank you for your efforts in this regard. Europäische Reiseversicherung AG

First name and last name of patient _____ Date of birth _____

1. Precise diagnosis (please write legibly):

   Course of therapy:

2. When did the patient become ill / When did the accident occur / When was the diagnosis made?
   (in case of pregnancy: when was pregnancy detected) Date D D M M Y Y Y Y
3. Is the ailment regarded as medically serious (i.e. sufficient to render patient unable to travel?)
   ☐ No ☐ Yes When did patient's inability to travel become apparent? Date D D M M Y Y Y Y

3a. In the event that a non-travelling family member (such as life partner, children, parents, siblings) was affected:
When did it become apparent that the presence of the insured was urgently needed? Date D D M M Y Y Y Y

4. Did the sickness or consequence of accident exist before **the policy was taken out / the travel booking was made?**
   ☐ No ☐ Yes - since when D D M M Y Y Y Y **→ if YES, please also answer questions 5 and 6**

Only to be completed in the case of existing sickness or consequence of accident:

5. On the date when **the policy was taken out / the travel booking was made** (Date D D M M Y Y Y Y)
   Were there any reservations about undertaking the trip? ☐ No ☐ Yes
   Could the patient reasonably expect to undertake the trip as planned? ☐ No ☐ Yes
   Had any serious unexpected deterioration occurred? ☐ No ☐ Yes
6. In the ☐ 9 months / ☐ 12 months **BEFORE THE POLICY WAS TAKEN OUT / THE TRAVEL BOOKING WAS MADE** was the patient receiving in-patient treatment in connection with the diagnosis stated above (excluding check up examinations)?
   ☐ No ☐ Yes
   In the 6 months **BEFORE THE POLICY WAS TAKEN OUT / THE TRAVEL BOOKING WAS MADE** was the patient receiving outpatient treatment in connection with the diagnosis stated above (excluding check up examinations)?
   ☐ No ☐ Yes

In order to avoid further requests please supply an extract from the medical file, in case of inpatient treatment a hospital report including anamnesis or in case of pregnancy a copy of the pregnancy record.

Space for additional comments:

With my signature, I hereby confirm the accuracy and completeness of the information I have provided above on my aforementioned patient travelling to their destination in _____ leaving on _____. I agree to share information verbally regarding the statements given, with the insurer's medical claims examiner. The insurer reserves the right to pursue appropriate legal means, as per §146 StGB, in the event that false information has been provided.

Which doctor is in the best position to provide information about the circumstances of this illness
(name, address and telephone number of the physician):

_____

_____ _____
Date, office stamp and signature of the attending physician

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