

Claim reports

Claim-No. _____

Cancellation costs

Dear Customer,

Unfortunately, you had to cancel your travel. To enable us to provide insurance services quickly and easily, we need some important information from you. Please complete this claim carefully and enclose the following documents if applicable.

- Travelling documents (cancellation settlement and booking confirmation)
- Medical certificate/death certificate/notice
- Medical certificate (to be completed by the attending physician for an amount of EUR 1,000.00 or more)
- Copy of the insurance policy

Thank you for your efforts.

Questions on the insurance holder (entitled person)

Name: _____

First given name: _____

Date of birth: _____

Road/House number: _____

Post code/Place: _____

Phone (reachable during the day): _____

E-mail address: _____

Account number (IBAN): _____

Bank code (BIC/SWIFT): _____

Questions on further insurance coverages.

1. Are you insured for cancellation costs with another company? ☐ yes ☐ no

Company _____

Policy no. _____

Questions on the planned travel.

2. Date of the booking order: _____

3. Date of the cancellation: _____

4. How many persons booked together? _____

5. How many of these cancelled? _____

6. What is the relationship between the travellers? _____

Questions on the event.

7. ☐ Un expected severe illness ☐ Accident ☐ Death ☐ Other

Brief summary of the case: _____

Confirmation and power of attorney

EUROPÄISCHE is released from the obligation to perform if the insured person tries to maliciously mislead EUROPÄISCHE about any circumstances relevant for the reason or the amount of the payments after a claim occurs.

I authorise doctors, hospitals and insurances of all kinds of providing EUROPÄISCHE Reiseversicherung AG with all required information and hereby release the above from their statutory confidentiality obligations.

Place and date _____

Signature of the damage originator or the statutory representative _____

Place and date _____

Signature of the insured person or the statutory representative _____

Medical Certificate

Claim-Nr. _____

Questions on the event

1. Date of the initial treatment in connection with the event: _____ Time of day _____
2. Precise diagnosis (no abbreviations): _____

3. Were treatments or follow-up examinations ordered? ☐ yes ☐ no
4. When did the patient fall sick/have the accident? _____ Date: _____
5. Were the complaints treated once/several times before already? ☐ yes ☐ no
If so, in which treatment period? _____ Date: _____
6. Anamnesis: _____

7. Has an unforeseeable severe deterioration occurred? ☐ yes ☐ no
When yes, when? _____
8. Was the patient unable to work? ☐ yes ☐ no
If so, from: _____ to: _____
9. Was there any in-patient treatment? ☐ yes ☐ no
If so, from when to when? (Please enclose a copy of the discharge report). _____
10. Was there any surgery? ☐ yes ☐ no
If so, date of the surgery: _____
11. When precisely was the surgery scheduled? _____ Date: _____

Questions on ability to travel.

12. Were there any medical concerns against starting the travel when the travel was booked? ☐ yes ☐ no
Reason: _____

13. When did it first become evident that the travel could not be started due to the health condition?
Date: _____
Why? _____

14. Did the patient inform you about his/her travel plans? ☐ yes ☐ no
If so, when? _____ Date: _____
15. When did you consider the patient able to travel again? _____ Date: _____

Further comments:

Place and date

Stamp and signature