



## CLAIMS FORM

### TRAVEL RISK INSURANCE

Code  PLEASE LEAVE BLANK

File no.  PLEASE LEAVE BLANK

**TIPS FOR COMPLETING THIS FORM!** Complete form entirely (including inside page and back page) and in block letters. Please state your bank account or giro number. Always enclose (a copy of) proof of your insurance. This can be the booking receipt on which the insurance details are printed. If there is not enough space on the form, please attach separate pages as required.

### Data insured

Name and initials	<input type="text"/>	Mr / Mrs	Date of birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	(Day - Month - Year)
Address	<input type="text"/>		Nationality	<input type="text"/>			
Postal code, city	<input type="text"/>	<input type="text"/>	City	<input type="text"/>			
Country	<input type="text"/>		Bank	<input type="text"/>			
Phonenumber	<input type="text"/>		Bank account no.	<input type="text"/>			
E-mail	<input type="text"/>		Attn	<input type="text"/>			

### Questions

### Answers

1 A	What is the name of the travel/insurance agent that issued the certificate of insurance?	Name and initials	<input type="text"/>		
B	What is the number of the policy of insurance? (Always enclose this policy)	Policy number	<input type="text"/>		
C	What is the commencing date of the insurance?	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
2	Purpose of journey/holiday destination	<input type="text"/>			
3	Has the emergency centre ELVIA Assistance been notified of the damage?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If yes, which file no.?	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
4	Was the damage caused by a third culpable party?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If so,	Name and initials	<input type="text"/>		
		Address	<input type="text"/>		
		Postal code, city	<input type="text"/>	<input type="text"/>	
		Country	<input type="text"/>		
5	Have you ever claimed damages on a travel risk insurance policy before?	<input type="checkbox"/> Yes	<input type="checkbox"/> No		
	If so, when and from which company?	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Company	<input type="text"/>		

### Complete questions 6 till 13 in case of medical expenses

6	Nature of the illness	<input type="text"/>			
7	When did you fall ill?	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
8	When was the first medical treatment received and who administered it?	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
		Name of physician	<input type="text"/>		
		Address	<input type="text"/>		
		Postal code, city	<input type="text"/>	<input type="text"/>	
		Country	<input type="text"/>		

<b>9</b> Have you suffered from this illness before?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, did you consult a physician concerning this illness prior to commencing your journey and on what date?	Name of physician <input type="text"/>
	Address <input type="text"/>
	Postal code, city <input type="text"/>
	Country <input type="text"/>
	Date of visit <input type="text"/>

<b>10</b> Were you receiving medical treatment on the commencing date of the insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, in what country and what town?	Name of physician <input type="text"/>
	Address <input type="text"/>
	Postal code, city <input type="text"/>
	Country <input type="text"/>
	Date of visit <input type="text"/>

<b>11</b> Is the condition the result of an accident?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If so, in what town and what country did the accident occur?	Town <input type="text"/>
	Country <input type="text"/>

<b>12</b> Under what circumstances or during what activities did the accident occur?	(Be explicit)

<b>13 A</b> With what organization are you normally insured against medical costs?	Name <input type="text"/>
	Address <input type="text"/>
	Postal code, city <input type="text"/>
	Country <input type="text"/>
<b>B</b> What is your policy number?	Policy number <input type="text"/>



**Specific information** (Outline the situation if possible)

Large empty rectangular area for providing specific information.

Information given by the insured in this form will be stored in a C.I.S. (Central Information System). The C.I.S. privacy regulations shall apply to this form.

The undersigned declares to have answered the above questions truthfully and without reservation and to be familiar with the insurance condition stating that by furnishing incorrect data or facts, the insured shall forfeit any right to compensation.

Have you filled in an account no.?

Signature	<input type="text"/>	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>
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