Claim Form Medical Services

Europäische Reiseversicherung AG, Kratochwjlestraße 4, A-1220 Vienna
Phone +43/1/317 25 00-73930, Fax +43/1/319 93 67-73930, E-mail: schaden@europaeische.at

Europäische Reiseversicherung

Please complete the form in full, using block capitals, and send it to us by post, fax or e-mail.

Claim No. _____
(this is assigned by the Europäische!)

1. Policy No. _____

☐ Mr. ☐ Mrs. First name _____ Last name _____

Street _____

Postal code _____ Place _____ Country _____

Date of birth _____ Phone _____ E-mail _____

Purpose of trip ☐ private ☐ business ☐ other _____

Profession _____

Departure date _____ Return date _____ Travel destination _____

2. Reason for your expenses

☐ Hospital stay ☐ Transport home ☐ Rescue services – provided by whom? _____

☐ Outpatient treatment ☐ Disability ☐ other reason _____

Amount of incurred costs € _____

3. Diagnoses _____

4. Description of the circumstances (please attach an additional page if space is not sufficient):
When and where did this event occur? Date _____ Place _____ Country _____

_____

_____

_____

5. Is medical treatment still on-going?

☐ No ☐ Yes – Name/Address of doctor and/or hospital _____

6. With which agency do you have national health insurance? National Health Service ID No. ☐☐☐☐☐☐☐☐☐☐☐

Gebietskrankenkasse | WIEN | NÖ | OÖ | S | T | VBG | STM | KTN | BGL | KFA | BVA | SVA | VAE | Others: _____

7. Do you own:

			Policy No.	Name of company
Private health/accident insurance	☐ No	☐ Yes –	_____	_____
Other travel insurance	☐ No	☐ Yes –	_____	_____
ARBÖ insurance	☐ No	☐ Yes –	_____	_____
Credit card	☐ No	☐ Yes – which?		

☐ Visa ☐ MasterCard ☐ DinersClub ☐ AmericanExpress ☐ _____ Card No. ☐☐☐☐☐☐☐☐☐☐☐☐ X X X X

☐ Visa ☐ MasterCard ☐ DinersClub ☐ AmericanExpress ☐ _____ Card No. ☐☐☐☐☐☐☐☐☐☐☐☐ X X X X

8. Have you already submitted a claim to any of the companies listed under Pt. 6 and/or 7?

☐ No ☐ Yes – with whom? (name and address) _____

Was this claim approved? ☐ No ☐ Yes – in what amount? € _____

To insure quick claim processing, please supply the following documents:

- Proof of insurance*
- Travel documents (e.g. booking confirmation)
- Copy of invoice for treatment costs / medicines plus proof of payment made by the health insurance fund **or** original invoice for treatment costs / medicines (costs reimbursement less excess)

* For credit card holders: proof of credit card usage for the duration of 3 months before insured event occurred = copy of monthly statement

I request that insurance benefits be deposited to the following account: Account Holder _____

Acct. No. _____ Branch No. _____ Bank _____

IBAN* _____ BIC Code* _____

* only for transfers to foreign banks

With my signature, I hereby confirm the accuracy and completeness of the information I have provided above.

Date _____ Signature _____

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