Claim Form for hotel bookings

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Europäische Reiseversicherung

To verify your claim we require and process your personal data in order to fulfil the insurance contract (Art. 6 Abs. 1 b) DSGVO) and if necessary your data concerning your health (§11a-d Insurance Contract Act - VersVG). For detailed information regarding the way in which we process your data please check europaeische.at/datenschutz.

Policy No. _____ Claim No. _____

A. Questions for the hotel or lessor

booked on _____ Period of stay from _____ to _____

When was the trip ☐ cancelled ☐ interrupted _____

Total trip price € _____ for _____ person(s)

Cancellation costs for _____ days € _____ representing _____ % of the trip price

Contact person for questions as may arise: Stamp/Signature hotel/lessor

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/interrupted their trip

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

Why was the trip cancelled/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 _____

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 | x |

☐ Visa ☐ MasterCard ☐ DinersClub ☐ AmericanExpress ☐ _____ Card No. | | | | | | | | | x | 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 – if part A is completed in full and signed by the hotel/lessor, the cancellation costs invoice is not necessary
- 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.)

I request that insurance benefits be deposited to ☐ guest ☐ hotel / lessor

☐ advance payment to the guest and final payment to the hotel / lessor

(Please indicate bank details of the guest)

into 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, release the physician from doctor-patient confidentiality obligations and agree with processing my personal data and in particular my data concerning my health for coverage clarification. I noticed the information sheet of data processing (europaeische.at/datenschutz).

Date _____ Signature _____

Policy 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 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** (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 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 WAS MADE** was the patient receiving outpatient treatment in connection with the diagnosis stated above (excluding check-up examinations)?
   ☐ No ☐ Yes

To avoid any further requirements, please provide us also with a copy of your medical file, in the case of existing illnesses/consequences of an accident, the complete medical history, in the case of an inpatient treatment, the hospital report including medical history or in case of pregnancy a copy of the maternity medical card.

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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