Claim Form
for hotel bookings

Europäische Reiseversicherung AG
Kratochwjlestraße 4, A-1220 Wien

Policy no. _____

Claim no. _____

A. Questions for the hotel or lessor

Period of stay from _____ **to** _____ **Travel destination** _____

Booked on _____ **Insurance taken out on** _____ **Purpose of trip** ☐ Private ☐ Business

When was the stay ☐ cancelled ☐ interrupted? Date _____

Total price EUR _____ for _____ person(s)

Cancellation costs EUR _____ for _____ days (Please enclose a list of cancellation costs)

Contact person for questions as may arise:

Name _____ Phone _____

E-Mail _____ Date _____

Stamp/Signature hotel/lessor:

B. Travellers who have cancelled/interrupted the trip

Please enclose additional sheet if there are more than 5 people

1. Traveller:

Salutation

Title, First- and Last name

Street, House no., Door no.

Date of birth

Zipcode, City, Country

Phone

E-Mail

2. Traveller:

Salutation

Title, First- and Last name

Street, House no., Door no.

Zipcode, City, Country

E-Mail

Phone

Date of birth

3. Traveller:

Salutation

Title, First- and Last name

Street, House no., Door no.

Zipcode, City, Country

E-Mail

Phone

Date of birth

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4. Traveller:

Salutation

Title, First- and Last name

Street, House no., Door no.

Zipcode, City, Country

E-Mail

Phone | Date of birth

5. Traveller:

Salutation

Title, First- and Last name

Street, House no., Door no.

Zipcode, City, Country

E-Mail

Phone | Date of birth

When did the event occur which led to cancellation/interruption? Date _____

Why was the trip cancelled/rebooked/interrupted? ☐ Illness ☐ Accident ☐ Death ☐ Pregnancy ☐ other _____

Person affected: Salutation _____ First Name _____ Last Name _____ Title _____

Date of birth _____ Relationship to the travellers? _____

In case of accident: Was the accident caused (in part) by third parties? ☐ No ☐ Yes - please enclose accident report – name/address of other party involved

Do you have any other cancellation insurance or a credit card? ☐ No ☐ Yes – which?

Insurer _____ Policy no. _____

Cardholder (to be completed by all travellers)	**Card no.**	**Trip or deposit for trip paid for with card**	
	XXXXXX	☐ No	☐ Yes
	XXXXXX	☐ No	☐ Yes
	XXXXXX	☐ No	☐ Yes
	XXXXXX	☐ No	☐ Yes
	XXXXXX	☐ No	☐ Yes

Have compensation claims been made to other insurance companies?

☐ No ☐ Yes – with whom? Name, address _____

Have you already received any compensation?

☐ No ☐ Being processed ☐ Yes - Amount EUR _____ (please enclose documents)

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The insurance benefit shall be paid into the following account

☐ guest

☐ hotel / lessor

☐ advance payment to the guest and final payment to the hotel / lessor (please indicate bank details of the guest)

Account holder

IBAN

BIC

We need your personal data to check your claim. Your personal data is processed on the basis of Article 6(1)(b) GDPR for the purpose of performing the insurance contract. Where health data is also required to check your claim, we process your health data on the basis of the power granted by Sections 11a to 11d of the Austrian Insurance Contract Act (VersVG). You can find more information about how we process your data at europaeische.at/en/legal/privacy

We always strive to meet the wishes of our customers and to improve. We therefore contact selected customers by e-mail after a claim has been processed for the purpose of obtaining feedback about quality and customer satisfaction. You can object to being contacted for this purpose at any time by sending an e-mail to vertragsmanagement@europaeische.at.

By signing, I confirm that the above information I have provided is accurate and complete and release my doctor from their obligation of confidentiality as a medical professional, insofar as this is necessary for my claims under the insurance contract to be checked.

Date _____ **Signature** _____

Claim Form PART C

Europäische Reiseversicherung AG
Kratochwjlestraße 4, A-1220 Wien

Policy no. or first 8 digits of credit card no. _____

Claim no. _____

C. Doctor's certificate (to be completed by the doctor)

(to be forwarded to Europäische Reiseversicherung AG)

To confirm that the patient is unable to travel due to illness/accident/pregnancy, please fill in the following form in full and accurately.

Attending doctor

Title, First- and Last name	Street, House no., Door no. .
Phone	Zipcode, City, Country

Patient

Title, First- and Last name	Street, House no., Door no.
Date of birth	Zipcode, City, Country

Travel destination _____ **Depature date** _____

1. Precise diagnosis (please write legibly):

2. Course of therapy:

3. When did the patient become ill / When did the accident occur / When was the diagnosis made? Date _____
(in case of pregnancy: when was pregnancy detected)

Hospital stay ☐ No ☐ Yes – from _____ to _____

Reported sick to your national health service provider ☐ No ☐ Yes – from _____ to _____

Claim Form PART C

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4. Is your patient unable to travel on this trip for medical reasons?

☐ No ☐ Yes – When did patient's inability to travel become apparent? Date _____

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 _____

5. Is this because of a pre-existing illness or the consequence of an accident? ☐ No ☐ Yes

6. Only to be completed in the case of existing illness or consequence of an accident:

Has the existing illness/consequence of an accident become acute unexpectedly? ☐ No ☐ Yes

When did the illness/consequences of the accident first occur? Date _____

In the last ☐ 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 last 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

Space for additional comments:

By signing, I confirm that the above information I have provided is accurate and complete. I undertake to provide the insurer's medical officers with information verbally about the relevant medical information. The insurer reserves the right to take legal action if information is untrue, in accordance with Section 146 of the Austrian Criminal Code.

Which doctor is in the best position to provide information about the circumstances of this illness?:

_____

Name, address and phone of the doctor

Date, office stamp and signature of the attending doctor