Claim Form Medical Services

Policy-Nr.:

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



Claim-Nr.:

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 VersVG). For detailed information regarding the way in which we process your data please check europaeische.at/datenschutz.

1. Policy No			
☐ Mr. ☐ Mrs. First name	l	_ast name	
Street			
Postal code Pla	ace	Country	
Date of birth	Phone	E-mail	
Purpose of trip ☐ private [☐ business ☐ other		
Departure date	Return date	Travel destination	
2. Reason for your expenses	7.T	· ' · · · · · · · · · · · · · · · · ·	
☐ Hospital stay ☐ ☐ Outpatient treatment ☐		vices – provided by whom?	
·	Disability United reason	on	
	ces (please attach an additional pa nt occur? Date	age if space is not sufficient): Place Country	
		: idoo	
5. Is medical treatment still on-g	oing?		
_	_		
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 insura			
Other travel insurance ARBÖ insurance			
Credit card	☐ No ☐ Yes – which?		
	Club American Express	Card No. XXXX	
☐ Visa ☐ MasterCard ☐ Diners	Club ☐ 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:			
I request that insurance benefits be deposited to the following account: Account Holder SWIFT/BIC			
IBAN	SWIFT/BIC	;	
		n I have provided above and agree with processing my personal data and ormation sheet of data processing (europaeische.at/datenschutz).	
Date		Signature	