Claim Form for hotel bookings

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Please complete the form in full, using block capitals, and send it to us by post, fax or e-mail. Policy No. (this is assigned by the Europäische!) A. Questions for the hotel or lessor booked on _____ Period of stay from ____ to ____ When was the trip ☐ cancelled ☐ interrupted _____ for ____ person(s) Total trip price € ____ Cancellation costs for _____ days € _____ representing _____ % of the trip price Contact person for questions as may arise: Stamp/Signature hotel/lessor Name B. Information on the traveller ☐ Mrs. First name _____ Last name ____ ☐ Mr. 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? Policy No. ☐ Visa ☐ MasterCard ☐ DinersClub ☐ AmericanExpress ☐ Card No. ☐ Visa ☐ MasterCard ☐ DinersClub ☐ AmericanExpress ☐ Card No. Card holder Have compensation claims been made to other insurance companies, and have any compensation payments been made? 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 - 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 - 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 \quad \quad \quad \text{quest} ☐ 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 ____ SWIFT/BIC **IBAN** With my signature, I hereby confirm the accuracy and completeness of the information I have provided above. I hereby release the physician from doctor-patient confidentiality obligations and expressly allow my information to be shared with my insurer. 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
Precise diagnosis (please write legibly):	
Course of therapy:	
2. When did the patient become ill / When did the accident occu	9
(in case of pregnancy: when was pregnancy detected)	Date L
3. Is the ailment regarded as medically serious (i.e. sufficient to rer	,
☐ No ☐ Yes When did patient's inability to travel becomes a. In the event that a non-travelling family member (such as life pa	
become apparent that the presence of the insured was urgently	needed? Date LIIIIII
4. Did the sickness or consequence of accident exist before the p	
☐ No ☐ Yes - since when ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐ ☐	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 LILI DOWN MM) Were there any reservations about undertaking the trip?	
Were there any reservations about undertaking the trip?	Y Y Y Y Y No □ Yes
Could the patient reasonably expect to undertake the trip as p	
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 V	WAS MADE was the nationt receiving outnation treatment in
connection with the diagnosis stated above (excluding check	
□ No □ Yes	
In order to avoid further requests please supply an extract from the medical file, in case of inpatient treatment a hospital report including anamnesis or in case of pregnancy a copy of the pregnancy record.	
Space for additional comments:	
Space for additional commonts.	
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):	Version 03/2015
	Date, office stamp and signature of the attending physician