

Notification of Claim

Claim no. _____

Healing Costs Insurance – Accident

Dear Client

In order to provide insurance services, we need some important information from you. Please carefully fill out this notice of damage, sign it, and enclose the following documents:

- Proof of entry to Switzerland/FL = copy of passport with stamp of date
- Police report
- Original receipts with prescriptions
- Original bills (doctor, hospital)
- Insurance policy/card (copy)

If you are not able to answer a question, please note the reason why.

Questions concerning the policy holder (person who concluded the insurance contract)

Name: _____

First name: _____ Date of birth: _____

Street/no.: _____

Zip code/city: _____

Phone (day time): _____ E-mail address: _____

Account Number (IBAN): _____

Bank Code (BIC/SWIFT): _____

Name and address of the bank: _____

Questions concerning the insured person

Date of entry to Switzerland/FL: _____

Date of leaving Switzerland/FL: _____

Name: _____ First name: _____

Date of birth: _____ Nationality: _____

Questions concerning the insurance

1. Date of purchase of policy or payment of premium: _____

2. Who arranged/concluded the insurance? _____

3. Insurance policy/membership card no.: _____

4. Do other insurances exist for this incident? yes no

5. If yes, which ones? _____

6. Has reimbursement already taken place or been applied for through another party? yes no

7. If yes, through whom? _____

Questions concerning the accident

8. Date of accident: _____ Time: _____

9. Scene of accident: _____

10. Exact description of injury: _____

11. Was the injured person under the influence of alcohol, medication, or drugs? yes no

12. Was a doctor consulted? yes no

13. If yes, when for the first time? _____ Date: _____

14. Name and address of the doctor in attendance: _____

15. Has the treatment been ended? yes no

16. If not, expected duration of treatment until: _____

17. Will there be further bills for this treatment? yes no

18. If yes, from whom? Name and address: _____

19. Who caused the accident? Name and address: _____

20. Insurance company of the responsible party: _____

21. Which means of transportation was used? _____

22. Was the injured person the driver of the vehicle? yes no

23. If yes, was s/he in possession of the required driving license? yes no

24. Under which circumstances did the accident happen? _____

25. Were other people involved in the accident? yes no

26. If yes, please give names and addresses: _____

27. Are there any eyewitnesses of the accident? yes no

28. If yes, please give names and addresses: _____

29. Did the police record the accident? yes no

30. If not, please give reasons: _____

Name of the insured person: _____ Date of birth: _____

EUROPÄISCHE will be released from the duty of payment if, after the event of damage, the insured person tries to deceive EUROPÄISCHE regarding circumstances that are relevant to the reason or the amount of the payment.

I authorize all doctors, medical institutions, and insurers to give EUROPÄISCHE Reiseversicherungs AG all necessary information about illnesses, disabilities, and injuries resulting from accidents, including those which exist currently and those which occurred previous to and during the period of insurance; furthermore, I hereby release the above mentioned from their legal duty of confidentiality.

Place and date

Signature of the insured person or his/her legal representative