

Notification of Claim

Claim no. _____

Healing Costs Insurance – Illness

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
- 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. Has a declaration of health been filled out? If yes, please enclose. _____

yes no

5. Do other insurances exist for this incident? _____

yes no

6. If yes, which ones? _____

7. Has reimbursement already taken place or been applied for through another party? _____

yes no

8. If yes, through whom? _____

Questions concerning the illness

9. Which illness was it (exact description)?

10. Was this a chronic illness? yes no

11. Was this a pre-existent illness? yes no

12. If yes, has the illness already been treated before? yes no

13. If yes, by which doctor? Name and address:

14. Was this an acute illness? yes no

15. Date of the first symptoms of the illness:

16. When did you consult a doctor for the first time?

17. Has the treatment been ended? yes no

18. If not, estimated duration of treatment until:

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

20. If yes, from whom? Name and address:

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 EURO-PÄISCHE 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