EUROPÄISCHE REISEVERSICHERUNGS AG, CLAIMS DEPARTMENT
P.O. BOX, CH-4002 BASEL, PHONE 058 275 27 27, FAX 058 275 27 30
CLAIMS@ERV.CH, WWW.ERV.CH

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 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