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

ERV

Notification of Claim

Claim no.

Cancellation Insurance Prior to Departure

Dear Client

Unfortunately you had to cancel your journey. In order to be able to perform services in a swift and uncomplicated manner, we require several important details from your part. Please fill in thoroughly the damage report and attach, if applicable, the following documents:

- Travel documents (booking confirmation and cancellation bill along with the organisers terms)
- Medical certificate/Death certificate
- If the requested amount is above CHF 1'000.–, the medical questionary has to be filled out by the treating doctor.
- Insurance policy/card (copy)

We appreciate your efforts.

Questions concerning the policyholder (eligible person)

Name:

First name: Date of birth:

Street/no.:

Zip code/city:

Phone (day time): E-mail address:

Account Number (IBAN): Bank Code (BIC/SWIFT):

Questions concerning further insurance coverages

1. Are you insured against cancellation fees with any other insurance company? ☐ yes ☐ no

   Company: Policy no.:

Questions concerning the planned journey

2. Date of definite booking:
3. Date of cancellation at the (travel agency/tour operator):
4. Number of travel participants:
5. How many of them cancelled?
6. How the travel participants relate to each other?

Questions concerning the event

7. ☐ Unexpected severe illness ☐ Accident ☐ Death ☐ Other:

   Brief summary of the case:

Confirmation and power of attorney

The EUROPEAN will be released from the duty of payment if, following the occurrence of an insured event, the insured person fraudulently attempts to deceive as to the circumstances which are material to the cause or extent of its liability to make payment.

I authorise physicians, health institutions and insurances of any kind to grant the EUROPEAN Travel Insurance AG all necessary informations and release hereby those named from their legal duty of confidentiality.

Place and date Signature of the perpetrator or the legal representative

Place and date Signature of the insured person or the legal representative

Medical Questionary

Claim no.

Questions concerning the event

1. Date of the first treatment in connection with this event: Time:
2. Please specify the exact diagnosis (no abbreviations):
3. Have there been any further treatments or follow-up consultations? ☐ yes ☐ no
4. When did the patient fall ill/have the accident? Date:
5. Were these disorders previously treated? ☐ yes ☐ no

   If yes, exact dates:
6. Anamnesis:
7. Did an unforeseeable severe deterioration occur? ☐ yes ☐ no

   If yes, when?
8. Was the patient unable to work? ☐ yes ☐ no

   If yes, from: until:
9. Was the patient hospitalized? ☐ yes ☐ no

   If yes, from when until when? (Please send a copy of the discharge report)
10. Was there a need to perform surgery? ☐ yes ☐ no

    If yes, surgery date:
11. When exactly was the surgery date arranged? Date:

Questions concerning the ability to travel

12. According to an objective medical assessment, were there any concerns against the travel plans? ☐ yes ☐ no

    Reason:
13. When was recognized for the first time that the journey could not be undertaken due to the state of health?

    Exact date:

    Reason:
14. Did the patient inform you about his/her travel plans? ☐ yes ☐ no

    If yes, exact date:
15. From which date on did you consider the patient to be fit to travel again? Exact date:

Further remarks

Place and date

Stamp and signature