

Claim Form



(Please use block letters)

Information about the insured

Travel period: From (day/month/year)	_____	To (day/month/year)	_____
First name(s)	_____	Date of birth (day/month/year)	_____
Family name(s)	_____	Sex (M/F)	<input type="checkbox"/>
Address	_____		
City	_____	Postal Code	_____
Country	_____	Tel. daytime	_____
Tel. evening	_____	Fax	_____
E-mail	_____		
Reimbursement address (if different from above)	_____		

Policy number	_____		_____

In case of illness / injury

Is this claim for: Illness Injury Accident Other

Where did the illness / injury occur? _____

Country _____ Date (day/month/year) _____

Diagnosis _____

Describe the course of the illness / injury (date of first symptom, etc.) _____

Have you previously had similar symptoms? YES NO If YES, when? _____

Describe the symptoms _____

Name of your doctor in country of permanent residence _____

Address _____

City _____ Postal Code _____

Telephone _____ Fax _____

A medical report must be included. If you need extra space in order to give a full description, please continue on a blank piece of paper.

In case of an accident

What happened? Describe the situation _____

In case of an accident, a police report must be submitted.

Names and addresses of witnesses, if any _____
