

Claim Reference No.:

\_\_\_\_\_ - \_\_\_\_\_



# Claim Form for Travel Cancellation- / Travel Curtailment- / Annulation-Insurances

Please complete in full.

Mondial Assistance International S.A.  
Niederlassung für Deutschland (Germany branch)  
Claims Department  
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## 1. Who booked the journey / event?

Please write your name in full.

<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	_____	_____
		First name(s)	Surname(s)
Street		Street Number	
Postcode		Place	
Place of work		e-mail	
Telephone (home)		Telephone (daytime)	

## 2. Travel / event details:

Tour operator / Service provider		
Booking / Travel agency		
Policy number (only if a policy was concluded)	Destination / Place of event	
_____	_____	_____
Booking date	Cancellation date	Journey / event interrupted / cut short
_____	_____	_____
Commencement of journey / event	End of journey / event	Delayed commencement of journey / event
_____	_____	_____
Total travel price in euros	Expected costs (Cancellation costs or return travel costs, additional return travel costs etc.) in euros	
_____	_____	

## 3. Please enter all participants whose journey / event was cancelled, started with a delay, interrupted or cut short:

<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	_____	_____
		First name / Surname 1. (Travel-)participant	Date of birth
<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	_____	_____
		First name / Surname 2. (Travel-)participant	Date of birth
<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	_____	_____
		First name / Surname 3. (Travel-)participant	Date of birth
<input type="checkbox"/> Mr	<input type="checkbox"/> Ms	_____	_____
		First name / Surname 4. (Travel-)participant	Date of birth

## 4. Why was the journey / event cancelled, started with a delay, interrupted or cut short?

<input type="checkbox"/> Illness (see 4.1)	<input type="checkbox"/> Accident (see 4.2)	<input type="checkbox"/> Death
<input type="checkbox"/> Pregnancy	<input type="checkbox"/> Other reason	When did it happen? _____

What other reason? \_\_\_\_\_

Which person was involved?

First name	Surname
_____	_____
Is this person related to the involved participants?	How?
<input type="checkbox"/> No <input type="checkbox"/> Yes	_____

If the surname is not identical to that of the person involved, please send us relevant proof of the family relationship existing between the persons.

Do you have any other travel cancellation- / annulation-insurance (credit card etc.) additional to your ELVIA Travel cover?

<input type="checkbox"/> No <input type="checkbox"/> Yes	_____
	Insurer / type of credit card (bank)

▶ Please enclose the following as evidence: a medical certificate stating the diagnosis and the exact treatment of the illness, injury or pregnancy. If such a report is not yet available, please pass on the attached form to the doctor giving treatment.

#### 4.1 In case of illness:

Name of illness

Symptoms

When did the illness occur?

2 0

When did the patient see a doctor?

2 0

Out-patient treatment  No  Yes

2 0  
from

2 0  
till

In-patient treatment  No  Yes

2 0  
from

2 0  
till

Unfit for work  No  Yes

2 0  
from

2 0  
till

Exact date when doctor was asked for the first time whether the patient was able to travel / to participate?

2 0

What was his opinion?

Has the patient been given medical treatment for the same or similar illness before?

Out-patient treatment  No  Yes

2 0  
from

2 0  
till

In-patient treatment  No  Yes

2 0  
from

2 0  
till

#### 4.2 In case of accident:

Place of accident

2 0  
Date of accident

Was the accident caused wholly or partly by a third party? (If Yes, please enclose accident report)

No  Yes

First name / Surname of accident perpetrator

Address of accident perpetrator

Liability Insurance of accident perpetrator (Company)

Policy number

Address of Liability Insurance of accident perpetrator

Did you claim compensation from that insurance? (If Yes, please enclose correspondence)

No  Yes

#### 5. Statement

I can assure that the information provided above is true and completed in good faith. I am aware that maliciously false and incomplete information will lead to the loss of my right to a claim even if the insurer does not suffer a disadvantage as a result thereof. Claims for damages against third parties will be passed on to Mondial Assistance.

Please state the name and address of the person entitled to receive the insurance benefit:

Other beneficiary:  see 1. beneficiary: First name Surname

Account number

Bank code

Name of Bank

For transfers from abroad:

IBAN

Swift- / BIC-Code

▶ If the reimbursement is to be received by a person other than the person booking the journey / event, the consent of such person is required.

Place / Date

Signature (Minors require the signature of a parent or guardian!)

We require the following documents to process the claim:

- Certificate of insurance
- Booking confirmation of journey / event
- Bill for cancellation costs, if applicable originals of unused tickets
- Proof of the occurrence of event insured (medical certificate, death certificate, etc.)

Enclosed:

- Yes  No
- Yes  No
- Yes  No
- Yes  No

In case of travel curtailment:

- Tour / event operator's invoice for (travel) services not used
- Original receipts for additional return travel costs, if insured

Enclosed:

- Yes  No
- Yes  No

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# Medical certificate

▶ Please complete A, B or C with your personal details and booking information, sign the declaration below and submit the form to the doctor giving treatment.

## A. Illness / accident of the insured person

<input type="checkbox"/> Mr <input type="checkbox"/> Ms	_____	_____
	First name	Surname
_____	_____	
Date of birth	Destination / Place of event	_____
_____	_____	_____
Booking date	Commencement of journey / event	End of journey / event
_____	_____	_____

### Illness /diagnosis which led to the insured person's inability to travel / to participate:

\_\_\_\_\_

Name of illness

\_\_\_\_\_

ICD 10 Code (Mandatory information)

When was the diagnosis given?

\_\_\_\_\_

Date

When did the patient first see a doctor about his / her symptoms?

\_\_\_\_\_

Date

Was the patient able to travel / to participate at that time?

Yes  No / Not reasonable

What medication and therapy / measures were prescribed?

\_\_\_\_\_

Any other information on treatment

\_\_\_\_\_

Referral to a specialist physician

No  Yes

\_\_\_\_\_

Name and address of the specialist physician

Was the insured person unfit for work?

No  Yes

\_\_\_\_\_

from

\_\_\_\_\_

till

Has the patient had any previous illnesses which have some connection to the present illness?

No  Yes

\_\_\_\_\_

since

Please state your diagnosis for the previous illnesses

\_\_\_\_\_

ICD 10 Code (Mandatory information)

If this is a chronic disease – when was the last acute episode?

\_\_\_\_\_

Date

Were you asked about whether the patient could travel / participate before the journey / event was booked? (See booking date above)

No  Yes

When was the first time that you were asked about patient's ability to travel / participate?

\_\_\_\_\_

Date

Health risks

No  Yes

\_\_\_\_\_

from

\_\_\_\_\_

till

Hospital / Clinic (Name and address)

\_\_\_\_\_

Name of the doctor referring patient for in-patient treatment (First name / Surname) ▶ Please enclose the discharge report of the hospital

When was it obvious that due to health reasons the booked journey / event was no longer possible?

\_\_\_\_\_

Date

Please give reasons if this information differs to that given on the date the patient saw you for the first time:

\_\_\_\_\_

(We reserve the right to have the data examined by the Medical Service of Mondial Assistance International S.A..)

\_\_\_\_\_

Place / Date

\_\_\_\_\_

Doctor's signature

\_\_\_\_\_

Doctor's stamp

