Allianz
Global Assistance

Insurance claim form

Accident ☐ Illness ☐

Code please leave blank

Dossier no. please leave blank

Tips for completion! Form to be completed in full (including back); please print. Do not forget to enter your bank account number. Always enclose a copy of your insurance certificate. A cover note listing the policy details may be substituted for the latter. Please enclose any explanatory notes on a separate sheet if there is not sufficient space on the form.

Details insured person

Name and initials m/f

Address

Zip code City

Phone number (day)

Phone number (evening)

E-mail

IBAN/Bank account no.

In the name of

Nationality

Date of Birth (day - month - year)

Questions and answers

1 Which branch issued the insurance policy?

Name
Address
Zip code City

2 A What is the number of your insurance policy?
(Please enclose original or copy)

Number

B Date of departure

Date (day - month - year)

C Duration of travel

Number of days

3 What was the date of the initial medical treatment?

Date (day - month - year)

4 Which physician provided the initial medical treatment?

Name and initials
City Country

5 Are you currently still receiving medical treatment? ☐ Yes ☐ No
(If yes, please give name and address of physician)

Name and initials (physician)
City

6 Name of your General Practitioner (GP) and city

Name and initials
City

7 A Who is your continuous insurer in respect of medical costs?
(A copy of the policy must always be enclosed)

Name
Address
Zip code City
Policy number

B Excess

Amount €

8 A Have you been in contact with Allianz Global Assistance , and if so, on which date? ☐ Yes ☐ No

Date (day - month - year)

B What is your dossier number at Allianz Global Assistance?

Dossier number

SF03*16.02

9 A Have you ever made a claim under any travel insurance policy? ☐ Yes ☐ No

(If yes, which company and when?)

Company

Date

B What is your dossier number at Allianz Global Assistance? Dossier number

Damage or injury relating to an accident

10 A What was the date and time of the accident? Date (day - month - year)

Time (hours - minutes)

B In which city/country did the accident occur, and in which location? City Country

11 A What caused the accident and what were the circumstances under which it occurred?

B During what activities did the accident occur? (If the accident occurred during a sports activity, please indicate clearly the type of sport)

12 Is a third person to blame for the accident in your opinion? (If yes, please give name and address of this person) ☐ Yes ☐ No

Name Address

City Country

13 What injury was sustained by the accident? (Please answer in detail)

14 According to the physician treating you at present, is there a risk of permanent disablement? ☐ Yes ☐ No

Damages relating to illness

15 On what date did the illness occur? Date (day - month - year)

16 Nature of disease

17 Have you suffered from this illness before? ☐ Yes ☐ No

If yes, did you consult a physician prior to the start of travel in respect of this illness? ☐ Yes ☐ No

And on what date? Date (day - month - year)

18 Were you receiving medical treatment at the time the insurance policy came into effect? ☐ Yes ☐ No

To be completed in case of accident and illness (please enclose original insurance notes and indicate whether they have been paid by you or otherwise)

Description	€	Amount	Paid
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Personal details entered on this form and any details which may be submitted later may be included in the insured persons administration of Allianz Global Assistance and in a central information system for insurance companies active in the Netherlands. Please contact Allianz Global Assistance if you have any questions and regarding the data protection rules which apply tot these records.

The undersigned declares • to have answered and provided the above questions and details accurately, truthfully and to the best of his/her knowledge, and not to have withheld any information relating to the loss or damage • to give permission herewith (in so far this is necessary) to the medical advisor(s) of Allianz Global Assistance to provide any relevant details to the medical advisor of Allianz Global Assistance in relation to the reason and background in case of medical treatment, admission to hospital and/or repatriation • to submit this claim form and details still to be provided to Allianz Global Assistance partially for the purpose of determination of the amount of the damages and entitlement to payment • to have taken note of the contents of this form • to be familiar with the condition that any entitlement to payment becomes invalid upon submission of incorrect/false details. Signing of this form signifies that you transfer entitlement to payments based on any insurance policy elsewhere to Allianz Global Assistance.

Date Signature