

Insurance claim form

Emergency Assistance Abroad

Code	<input type="text"/>	please leave blank
Dossier no.	<input type="text"/>	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. The 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	<input type="text"/>	m/f	E-mail	<input type="text"/>
Address	<input type="text"/>		IBAN	<input type="text"/>
Zip code	<input type="text"/>	City	<input type="text"/>	In the name of
Phone number (day)	<input type="text"/>		Nationality	<input type="text"/>
Phone number (evening)	<input type="text"/>		Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> (day - month - year)

Questions and answers

1 Which branch issued the insurance policy?	Name	<input type="text"/>
	Address	<input type="text"/>
	Zip code	<input type="text"/> City <input type="text"/>
2 What is the number of your insurance policy? (Please enclose copy of the policy)	Number	<input type="text"/>
3 A Date of departure	Date	<input type="text"/> <input type="text"/> <input type="text"/> (day - month - year)
B Duration of travel	Number of days	<input type="text"/>
C Purpose of travel/Holiday destination		<input type="text"/>
4 Have you been in contact with the Emergency Centre of Allianz Global Assistance, and if so, on which date?		<input type="checkbox"/> Yes <input type="checkbox"/> No
	Date	<input type="text"/> <input type="text"/> <input type="text"/> (day - month - year)
	Dossier number	<input type="text"/>

Questions 5-9 must only be answered in case of recall or premature termination of the trip

5 A Please explain as briefly as possible what exactly occurred and who were involved (Please indicate family relationship, if necessary on a separate sheet of paper)

B Name and address of the person under question 5 A?	Name and initials	<input type="text"/>
	Date of Birth	<input type="text"/> <input type="text"/> <input type="text"/> (day - month - year)
	Address	<input type="text"/>
	Zip code	<input type="text"/> City <input type="text"/>
C Who is your General Practitioner (GP)?	Name and initials	<input type="text"/>
	Phone number	<input type="text"/>
	Address	<input type="text"/>
	Zip code	<input type="text"/> City <input type="text"/>
D Who was the physician providing treatment?	Name and initials	<input type="text"/>
	Phone number	<input type="text"/>
	Address	<input type="text"/>
	Zip code	<input type="text"/> City <input type="text"/>



6 A What was the state of health of the person for whom you returned at the start of the trip?

B Was this person already having medical treatment upon commencement of your trip? Yes No
If yes, how long for and in relation to what?

C If illness was the reason for your premature return, we would like to know what the illness in question was.

7 Which means of transport were used for the outward journey?

8 A Have you already submitted a request for reimbursement of unused or partially used tickets for the return journey? Yes No

B What is the amount of the sum reimbursed? Amount €

9 What additional costs did you incur in relation to the return journey?
(Please enclose original invoices and tickets)

Description	€	Amount	Paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Questions 10-12 to be answered only in case of a longer trip

10 A What event do you base this claim on? (Please enclose statement by physician if necessary)

B Name and address of the person under question 10 A?

C Please explain as briefly as possible what exactly occurred and who were involved (Please indicate family relationship, if necessary on a separate sheet of paper)

11 A How many days have you had to spend longer abroad (on the advice of your doctor) after expiry of the insurance period?
(Please enclose statement by physician) (Number of additional days)

B Name and address of the physician or specialist providing treatment abroad

Name and initials

Address

Zip code City

Country

12 What costs were incurred? (Please enclose original invoices)

Description	€	Amount	Paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No

Question 13 to be answered only in case of loss or damages incurred

13 A What event caused your return to be urgently required?

B Why was your presence necessary? (Please enclose statement by fire brigade or other organisation)

Question 14 to be answered only in case of avalanches, landslides, floods and strikes of transport companies

14 A What is the reason for the additional costs incurred?

B On what date was it possible for you to leave again? Date (day - month - year)
(Please enclose statement by the local police, municipality or transport companies)

C On what date would you have left originally? Date (day - month - year)
What is the amount of the additional travel and/or accommodation costs?

Description	€	Amount	Paid
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="checkbox"/> Yes <input type="checkbox"/> No



Question 15 to be answered only in case the driver was unable to drive the vehicle

15 A What injury or illness prevented the continuation of the journey on which date? (Please enclose statement by physician)	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	(day - month - year)
B On what date was the return journey home (in The Netherlands) commenced?	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	(day - month - year)
C What is the amount of the additional travel costs home (in The Netherlands) from the location the driver was unable to continue?	Amount	<input type="text"/>			
D What is the amount of the additional return journey and/or accommodation costs?	Amount	<input type="text"/>			

Questions 16-17 to be answered only in case of breakdown of the private motor vehicle and/or trailer

16 A Registration no. motor vehicle	Registration no.	<input type="text"/>	<input type="text"/>	<input type="text"/>	
B In whose name is the vehicle registered?	Name	<input type="text"/>			
C Make and type of motor vehicle, as well as year of manufacture	Make and model	<input type="text"/>			
	Year manufactured	<input type="text"/>			
D What is the cause of the damage?	<input type="text"/>				
E What does the damage to the motor vehicle/trailer consist of?	<input type="text"/>				
F Where did this occur?	City	<input type="text"/>			
G On which date and time?	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	(day - month - year)
	Time	<input type="text"/>	<input type="text"/>	(hours-minutes)	
H When did you book the motor vehicle and/or trailer in for repair and at which garage? (Please enclose statement from garage manager)	Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	(day - month - year)
	Garage	<input type="text"/>			
I Was repair within 2 working days possible?					<input type="checkbox"/> Yes <input type="checkbox"/> No
J Do you have an international circular letter of credit?					<input type="checkbox"/> Yes <input type="checkbox"/> No
K Do you have a 'short-term vehicle insurance policy'?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, with which company?	Company	<input type="text"/>			
L Do you hold a continuous third-party and/or comprehensive insurance policy?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, with which company?	Company	<input type="text"/>			
17 A Was another party involved and do you deem them liable?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, why?	<input type="text"/>				
	<input type="text"/>				
Name and address of the other party	Name and initials	<input type="text"/>			
	Address	<input type="text"/>			
	Zip code	<input type="text"/>	City	<input type="text"/>	
B Is repair possible? (If no, please enclose statement from garage)					<input type="checkbox"/> Yes <input type="checkbox"/> No
C Has an official record been compiled?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, by whom and where?	Name and initials	<input type="text"/>			
	City	<input type="text"/>			
D Is the trailer also insured elsewhere?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, with which company and what is the policy number?	Company	<input type="text"/>			
	Policy number	<input type="text"/>			

General

18 If you have incurred damage or loss as a result of reasons other than above, what is the reason for the additional accommodation/return journey costs?



Specifications

Description	€	Amount	Paid
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No

Additional notes (if necessary sketch of the situation)

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 to 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