HanseMerkur
Reiseversicherung AG

Name and address of policyholder

Abt. RLK-Leistung

Servicebüro Wien
Untere Donaustr. 47
1020 Wien
Tel.: 01 3177-859
Fax: 01 3177-860
E-Mail: Reiseleistung@hansemerkur.at

Travel Cancellation Claim Form

Claim no: _____ _____

Dear Policyholder
Unfortunately you have had to cancel your trip. In order to process your claim efficiently we require specific information from you. Please complete this form as accurately as possible to avoid any unnecessary queries. Thank you for your cooperation and do not hesitate to contact us if anything is unclear to you.

I. Travel details:

1) Tour operator: _____ Country of destination _____

2) Travel agency: _____

3) Start of travel: _____ Finish: _____

4) Booked on: _____ Cancelled on : _____

II. Details of travellers who cancelled the trip (name, address, date of birth)

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

III. Name and address of the person who has initiated the claim:

_____

Also state the relationship of this person provided that he or she is not one of the travellers

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IV. Reason for cancellation:

Illness **Accident**	☐ ☐	} ➔	Please have the enclosed questionnaire completed by the doctor consulted
Pregnancy	☐	➔	Please enclose a medical certificate issued by the doctor or gynaecologist consulted
Vaccination incompatibility	☐	➔	Please enclose a medical certificate issued by doctor consulted
Unemployment	☐	➔	Please enclose your employer's letter of termination and unemployment certificate issued by the employment office.
Death	☐	➔	Please enclose a copy of the death certificate and details of the relationship between you and the deceased.

Other reasons: _____

In the event that the claim incident (e.g. accident) was caused by a third party, please state the exact name and address of this person and,in the case of a road accident, if possible, the police station

_____

When did the incident occur? _____

In the event of illness: Were you unable to work? ☐ No ☐ Yes
If yes, please attach a copy of the certificate of disability to the claim documents and state the name and address of your employer below:

_____

V. Discontinuation of travel:

Reason for discontinuation: _____

Date of discontinuation of travel: _____

If you discontinued your travel, please submit the original receipts covering the additional return journey costs, such as hotel bills, air tickets, train tickets, etc.

VI. Who should receive the claim settlement? (name, address, telephone no., bank account, IBAN, BIC / Swift / ABA)

_____

_____

Policyholder's signature

VII. The following documents are also required for claim processing reasons:

Insurance policy	☒	**Evidence of premium payment**	☒
Travel booking confirmation (copy)	☒	**Tour operator's travellers' list (group travel)**	☐
Cancellation invoice (original)	☒	**Tour operator's travel terms and conditions**	☐
Rental agreement (original)	☐	**Rental terms and conditions**	☐
Air ticket (original)	☐	**Evidence of additional return journey costs**	☐

Please do not staple or attach documents. Thank you for your help.

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Insurance no.:
(Please quote unless already provided)

Claim no.: ___
(Please quote if known)

VIII. Information on the consequences of breach of duty after the insured incident has occurred

Information under Sec. 28 para. 4 VVG

Dear customer

After the insured incident has occurred, we require your assistance.

Duty to provide information and assist in clarification
On the basis of the contractual agreement entered into, we may ask you to provide us with all information that is necessary to clarify the scope of liability (duty to provide information) and to clarify the matter fully (duty of clarification) to enable us to fully assess the claim. However, we may also request that you provide us with supporting documents, provided that such requests are reasonable.

Loss of benefits
If, contrary to the contractual agreements, you fail to provide us with information or give incorrect information, or wilfully fail to provide us with the supporting documents that we request, you will lose your entitlement to compensation. If breach of such obligations is based on gross negligence, we may reduce the benefits in proportion to the seriousness of the negligence. There will be no reduction if you prove that you have not been grossly negligent in infringing the obligations.

Notwithstanding a breach of your obligation to either provide information, assist in clarification, or provide supporting documents, we are still obliged to pay compensation insofaras you can prove that any violation of duty was neither the result of establishing the scope of the insured incident or the scope of our liability.

If you fraudulently breach the obligation to provide information to clarify matters or to provide supporting documents, we will in every case be released from our liability to pay the claim.

Note:
If a third party, and not you yourself, is entitled to the benefits under the contract, such third party must also provide information assist in clarifying matters and provide supporting documents.

Place: _____ **Date:** _____

_____
Signature of policyholder and insured or legal representative

IX. Final statement

I confirm that the information I have provided above is true and complete. I am aware that incorrect or incomplete information may lead to loss of insurance cover. I have taken note of the above information in accordance with Sec. 28 para. 4 of the Insurance Contract Act on the consequences of breach of obligation after the insured incident.

In addition I assign my claims and demands against a third party causing the accident / liable party or against my statutory health insurance fund / private health insurer to the amount of the compensation paid by HanseMerkur Reiseversicherung AG to HanseMerkur Reiseversicherung AG.

Place: _____ **Date:** _____

_____
Signature of policyholder and insured or legal representative

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X. Release from duty of confidentiality and medical certificate

Claim no.: ___

Dear Insured

Would you please sign the following declaration and forward it to the doctor consulted. If you yourself are not ill, please arrange for the release from the duty of confidentiality to be signed by the sick person (e.g. parents, children, grandparents, etc.) or the fellow traveller in question. The declaration does not represent a general release from the duty of confidentiality, but covers only information on the illness leading to the cancellation or cessation of the trip.

Note:

You or the person for whom health-related data is to be collected, have the right to refuse to release doctors and other parties from the duty of confidentiality. In such a case any obligation on the part of HanseMerkur Reiseversicherung AG to pay benefits will be suspended, at least until a date when it can reassess its liability.

Release from duty of confidentiality:

I am aware that HanseMerkur Reiseversicherung AG may obtain information on the illness (es) which led to the cancellation of the trip to assess its liability, and may check information provided to substantiate a claim. For this purpose, I release the under-mentioned members of healthcare professions or hospitals, as well as health insurance funds and health insurers that are named in the documents submitted by me, or who were involved in the treatment, from their duty of confidentiality. This release shall also apply after my death. With regard to any treatment carried out in the past by a doctor, dentist or other member of the health profession, this release from the duty of confidentiality shall apply only to such information as is required to enable HanseMerkur Reiseversicherung AG to reassess its liability.

I release the following doctors and other members of the health profession from their professional duty of confidentiality (please provide full names and addresses):

1.) _____

2.) _____

3.) _____

4.) _____

I also make this declaration for my co-insured children, if any, and for any additional people who I legally represent who are unable to assess the significance of this declaration themselves.

A copy of this authorisation is also valid.

_____ _____

Place, date Signature of person on whom data is to be collected

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Medical certificate:

Insurance no:
Claim no: ___

Dear Doctor
To enable us to assess our liability under the travel cancellation insurance, we would be grateful if you could complete the following questions (in capital letters). If there is insufficient space, please use the reverse page for your answers.

Patients name Date of birth

Street, postal/zip code, town/city, country

1. a) Exact diagnosis with ICD code: _____

   b) Previous case history (use additional sheet if necessary): _____

2. When was the diagnosis made or when did the accident occur? _____
3. When did the patient first see a doctor because of these complaints? _____
4. a) Was the patient unable to work? ☐ No ☐ Yes, from _____ to _____
   If yes, please attach a copy of the certificate regarding inability to work
   b) If no, please give reasons: _____
5. Treatment as an in-patient? ☐ No ☐ Yes, from _____ to _____
   If yes, please attach the discharge report and the findings on admission.
6. What treatment was prescribed? Please also give details of prescribed medicines.
7. a) When was specific treatment carried out as a result of this illness? Please give dates.

   b) What specific examinations were carried out? _____
8. a) Had the patient already suffered from the complaint? ☐ No ☐ Yes, since when? _____
   b) When did specific treatment take place in respect to the above illness(es)?
   Please give details of dates_____

   c) When did treatment take place due to the condition worsening?
9. a) Were you asked **before** the trip was booked on _____ * (date) whether the patient was able to travel? ☐ No ☐ Yes, for the first time on _____
   b) If yes, what did you advise or point out to the patient and/or dependants?
10. Were you asked about the ability to travel **after** the booking date *?
    ☐ No ☐ Yes, for the first time on _____
    for the last time on _____
11. When did you advise against starting the trip? Date _____
    last time on _____
12. Did maybe you refer your patient to a specialist? ☐ No ☐ Yes, on: _____

Please write the name and address of the specialist here.

Stamp and signature of the doctor **Place and date**

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