CORPORATE BENEFIT PLAN

Policy No. _____

Claim No. _____
(Filled out by Europæiske)

CLAIM FORM FOR CANCELLATION

The claim for compensation is regarding

Name of your firm		What is your job title?	
First name and surname		Date of birth (CPR No.)	
Street address		Phone - mobile	Phone
Postal code	City	Email	

Credit card and insurance details

What kind of credit card do you have (e.g. MasterCard, Eurocard, Globecard)? _____

Is the credit card issued by a bank? ☐ Danske Bank ☐ Nordea ☐ Other _____

Card No. _____ Is your claim reported to the credit card company? ☐ Yes ☐ No

I do not have a credit card ☐ Did you purchase your journey using your credit card? ☐ Yes ☐ No

Do you have another cancellation insurance? If yes,

Company _____ Policy No. _____ Is your claim reported to the insurance company? ☐ Yes ☐ No

Travel details

Order date	Cancellation date	What is the purpose of your journey?
Planned departure	Planned date of return	Destination (city and country)

Other travellers who's journey was cancelled

First name and surname	Date of birth (CPR No.)
First name and surname	Date of birth (CPR No.)
First name and surname	Date of birth (CPR No.)

Reason for cancellation

When did the incident that caused the cancellation occur? _____

☐ Illness/injury Diagnosis/description of the illness _____ ☐ Death

Please state relation ☐ Insured ☐ Cohabite(e) ☐ Family, please state relation _____

The patient and the patient's doctor must fill out and sign the medical certificate on the back

☐ Burglary Where? _____

☐ Fire Where? _____

☐ Other Please describe _____

Compensation claimed

State you claim in DKK _____

How much compensation have you received from the travel agent? (please enclose original documentation) DKK _____

Method of payment

Bank reg. No. and account No. _____ IBAN No _____

Name and address of the bank _____ Swift code _____

Signature etc.

Unused tickets and invoice from the travel agent must be enclosed along with your claim form.

I declare that all the statements in this claim form are correct and that I have not concealed anything. I understand that providing incorrect information will forfeit the claim and may result in termination of the insurance.

_____ Date / 20

Insured's signature

Frederiksberg Allé 3
1790 København V

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Fax +45 33 25 29 49 (kl 9.00 - 16.00)

erhverv-skade@er.dk
www.er.dk

CVR 62940514

EUROPÆISKE ERV

EI I 17_02.12

MEDICAL CERTIFICATE

Paid by the insured

This medical certificate must be filled out as soon as possible if the cause of cancellation is illness and send to Europæiske.

The patient's details

To be filled out if the patient is different from the insured

Name	Address
Postal code and city	Phone

Consent

I hereby give my consent/power of attorney to Europæiske to procure and forward information about the state of my health from authorised persons within the health care sector, hospitals and health care institutions, public authorities, insurance companies/pension funds, Ankenævnet for Forsikring. The consent/power of attorney only covers this claim.

I declare that all the statements in this claims form are correct and that I have not concealed anything.

Date / 20

Patient's/insured's signature

To be filled out by the patient's doctor

Patient's name	Date of birth (CPR No.)

Description of illness (please state accurate diagnosis) _____

Is the illness regarded as acute?

☐ Yes ☐ No If, no please answer the questions about chronic illness.
Acute illness covered by the insurance is acute illness or justified suspicion of acute, serious illness.

When did the patient show symptoms of this illness?	Date of 1st attendance	Was the illness known when the journey was booked? ☐ Yes ☐ No

If the illness is chronic. When did the patient develop the illness?	Has an acute aggravation occurred? ☐ Yes ☐ No If yes, when?

When did you recommend cancellation due to the state of the patient's health?

Medical comments

The doctor's name, address, postal code, city, phone and SE-number (if Danish doctor)

Are you the patient's general practitioner?

☐ Yes ☐ No If no, please state name of the patient's general practitioner _____

Date / 20

Doctor's signature

Any expenses for the completion of this form are at the insured's expense.

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