ERV, CLAIMS DEPARTMENT, P.O. BOX, CH-4002 BASEL
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ERV | interchalet

Claim reports

Claim-No.

Cancellation costs

Dear Customer,

Unfortunately, you had to cancel your travel. To enable us to provide insurance services quickly and easily, we need some important information from you. Please complete this claim carefully and enclose the following documents if applicable.

- ☐ Travelling documents (cancellation settlement and booking confirmation)
- ☐ Medical certificate/death certificate/notice
- ☐ Medical certificate (to be completed by the attending physician for an amount of EUR 1,000.00 or more)
- ☐ Copy of the insurance policy

Thank you for your efforts.

Questions on the insurance holder (entitled person)

Name:

First given name: Date of birth:

Road/House number:

Post code/Place:

Phone (reachable during the day): E-mail address:

Account number (IBAN): Bank code (BIC/SWIFT):

Questions on further insurance coverages.

1. Are you insured for cancellation costs with another company? ☐ yes ☐ no

   Company Policy no.

Questions on the planned travel.

2. Date of the booking order:
3. Date of the cancellation:
4. How many persons booked together?
5. How many of these cancelled?
6. What is the relationship between the travellers?

Questions on the event.

7. ☐ Un expected severe illness ☐ Accident ☐ Death ☐ Other

   Brief summary of the case:

Confirmation and power of attorney

ERV is released from the obligation to perform if the insured person tries to maliciously mislead ERV about any cir-cumstances relevant for the reason or the amount of the payments after a claim occurs.

I authorise doctors, hospitals and insurances of all kinds of providing ERV with all required information and hereby release the above from their statutory confidentiality obligations.

Place and date Signature of the damage originator or the statutory representative

Place and date Signature of the insured person or the statutory representative

Medical Certificate

Claim-Nr.

Questions on the event

1. Date of the initial treatment in connection with the event: Time of day
2. Precise diagnosis (no abbreviations):
3. Were treatments or follow-up examinations ordered? ☐ yes ☐ no
4. When did the patient fall sick/have the accident? Date:
5. Were the complaints treated once/several times before already? ☐ yes ☐ no

   If so, in which treatment period? Date:
6. Anamnesis:
7. Has an unforeseeable severe deterioration occurred? ☐ yes ☐ no

   When yes, when?
8. Was the patient unable to work? ☐ yes ☐ no

   If so, from: to:
9. Was there any in-patient treatment? ☐ yes ☐ no

   If so, from when to when? (Please enclose a copy of the discharge report).
10. Was there any surgery? ☐ yes ☐ no

    If so, date of the surgery:
11. When precisely was the surgery scheduled? Date:

Questions on ability to travel.

12. Were there any medical concerns against starting the travel when the travel was booked? ☐ yes ☐ no

    Reason:
13. When did it first become evident that the travel could not be started due to the health condition?

    Date:

    Why?
14. Did the patient inform you about his/her travel plans? ☐ yes ☐ no

    If so, when? Date:
15. When did you consider the patient able to travel again? Date:

Further comments:

Place and date

Stamp and signature