European Travel Insurance ERV, Claims Department
P.O. Box, CH-4002 Basel, +41 58 275 27 27
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Notification of Claim

Claim no.

Healing Costs Insurance – Accident

Dear Client

In order to provide insurance services, we need some important information from you. Please carefully fill out this notice of damage, sign it, and enclose the following documents:

- Police report
- Original receipts with prescriptions
- Original bills (doctor, hospital)
- Original or copy of the credit card statement showing that at least 80% of the purchase price was paid with the card

If you are not able to answer a question, please note the reason why.

Questions concerning the policy holder (person who concluded the insurance contract)

Name:

First name: Date of birth:

Street/no.:

Zip code/city:

Phone (day time): E-mail address:

Account Number (Neon-IBAN):

Questions concerning other insurances

1. Do other insurances exist for this incident? ☐ yes ☐ no
2. If yes, which ones?
3. Has reimbursement already taken place or been applied for through another party? ☐ yes ☐ no
4. If yes, through whom?

Questions concerning the accident

5. Date of accident: Time:
6. Scene of accident:
7. Exact description of injury:
8. Was the injured person under the influence of alcohol, medication, or drugs? ☐ yes ☐ no
9. Was a doctor consulted? ☐ yes ☐ no
10. If yes, when for the first time? Date:
11. Name and address of the doctor in attendance:
12. Has the treatment been ended? ☐ yes ☐ no
13. If not, expected duration of treatment until:
14. Will there be further bills for this treatment? ☐ yes ☐ no

15. If yes, from whom? Name and address:

16. Who caused the accident? Name and address:

17. Insurance company of the responsible party:

18. Which means of transportation was used?

19. Was the injured person the driver of the vehicle? ☐ yes ☐ no

20. If yes, was s/he in possession of the required driving license? ☐ yes ☐ no

21. Under which circumstances did the accident happen?

22. Were other people involved in the accident? ☐ yes ☐ no

23. If yes, please give names and addresses:

24. Are there any eyewitnesses of the accident? ☐ yes ☐ no

25. If yes, please give names and addresses:

26. Did the police record the accident? ☐ yes ☐ no

27. If not, please give reasons:

Name of the insured person: Date of birth:

ERV will be released from the duty of payment if, after the event of damage, the insured person tries to deceive ERV regarding circumstances that are relevant to the reason or the amount of the payment.

I authorize all doctors, medical institutions, and insurers to give ERV all necessary information about illnesses, disabilities, and injuries resulting from accidents, including those which exist currently and those which occurred previous to and during the period of insurance; furthermore, I hereby release the above mentioned from their legal duty of confidentiality.

Place and date Signature of the insured person or his/her legal representative