Claim Reference No.:

Allianz Travel

Claim Form for Travel Cancellation- / Travel Curtailment- / Annulation-Insurances

Please complete in full.

AWP P&C S.A., Niederlassung für Deutschland
Schadenabteilung
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Tel: +49.89.6 24 24-299 · Fax: +49.89.6 24 24-177
E-Mail: ruecktrittschaden-awpde@allianz.com

1. Who booked the journey / event?

Please write your name in full.

☐ Mr ☐ Ms

First name(s) | Surname(s)

Street | Street Number

Postcode | Place

Telephone / Mobile | e-mail

2. SEPA Bank Transfers

For international (non-SEPA) bank transfers, please provide your full bank details separately.

Who is entitled to receive the insurance benefit?

☐ see 1. **or other beneficiary:**

First name | Surname

IBAN | Swift- / BIC-Code

3. Travel / event details:

Do you have any other travel cancellation- / annulation-insurance (credit card etc.) additional to this cover?

☐ No ☐ Yes

Insurer / type of credit card (bank)

Insurance number or credit card number, including name of bank

Booking date | Commencement of journey / event | Journey / event interrupted / cut short

Cancellation date | End of journey / event | Delayed commencement of journey / event

Total travel price in euros | Amount of costs alleged (Cancellation costs, return travel costs etc. in euros)

▶ Please attach schedule of required cancellation costs, if applicable.

4. Please enter all participants whose journey / event was cancelled, started with a delay, interrupted or cut short:

☐ Mr ☐ Ms First name / Surname 1. (Travel-)participant — Date of birth

☐ Mr ☐ Ms First name / Surname 2. (Travel-)participant — Date of birth

☐ Mr ☐ Ms First name / Surname 3. (Travel-)participant — Date of birth

☐ Mr ☐ Ms First name / Surname 4. (Travel-)participant — Date of birth

Please note

We require the following documents to process the claim: — **Enclosed:**

- Certificate of insurance ☐ Yes ☐ No
- Booking confirmation of journey / event ☐ Yes ☐ No
- Bill for cancellation costs, if applicable originals of unused tickets ☐ Yes ☐ No
- Proof of the occurrence of event insured (medical certificate, death certificate, etc.) ☐ Yes ☐ No
- Itemised list of costs incurred ☐ Yes ☐ No

In case of travel curtailment: — **Enclosed:**

- Tour / event operator's invoice for (travel) services not used ☐ Yes ☐ No
- Original receipts for additional return travel costs, if insured ☐ Yes ☐ No

▶ see reverse

5. Why was the journey / event cancelled, started with a delay, interrupted or cut short?

☐ Illness (see 5.1) ☐ Accident (see 5.2) ☐ Death

☐ Pregnancy ☐ Other reason **When did it happen?** | | | | | | | | |

What other reason?

Which person was involved?

First name Surname

Is this person related to the involved participants? ☐ No ☐ Yes **How?**

If the surname is not identical to that of the person involved, please send us relevant proof of the family relationship existing between the persons.

Please enclose the following as evidence: a medical certificate stating the diagnosis and the exact treatment of the illness, injury or pregnancy. If such a report is not yet available, please pass on the attached form to the doctor giving treatment.

5.1 In case of illness:

Name of illness / health complaints / symptoms

			When did the illness occur?	When did the patient see a doctor?
Out-patient treatment	☐ No	☐ Yes	from	till
In-patient treatment	☐ No	☐ Yes	from	till
Unfit for work	☐ No	☐ Yes	from	till

Exact date when doctor was asked for the first time whether the patient was able to travel / to participate?

What was his opinion?

Has the patient been given medical treatment for the same or similar illness before?

Out-patient treatment	☐ No	☐ Yes	from	till
In-patient treatment	☐ No	☐ Yes	from	till

5.2 In case of accident:

Place of accident Date of accident

Was the accident caused wholly or partly by a third party? (If Yes, please enclose accident report / brief description of accident) ☐ No ☐ Yes

First name / Surname and Address of accident perpetrator

Liability Insurance of accident perpetrator (Company) Policy number

Address of Liability Insurance of accident perpetrator

Did you claim compensation from that insurance? (If Yes, please enclose correspondence) ☐ No ☐ Yes

6. Data Protection

We process your personal data in compliance with the EU General Data Protection Regulation (GDPR), the German Federal Data Protection Act (Bundesdatenschutzgesetz, BDSG), the data protection provisions of the German Insurance Contracts Act (Versicherungsvertragsgesetz, VVG) as well as all other applicable laws. The processing of special categories of personal data – including health data – is subject to special protection. By providing us with health data in connection with your claim, you give us explicit permission to process the health data necessary for processing the claim.

7. Instructions on duty of truthfulness (Section 28 of the German Insurance Contract Act [VVG])

The above details are true and have been given to the best of my knowledge. I have noted that intentionally false or incomplete details can result in a loss of insurance benefits. If false or incomplete details are provided through gross negligence, the insurance company can reduce the insurance benefits in proportion to the degree of fault. The insurance benefits will not be reduced if I can furnish proof that false or incomplete details were not provided through gross negligence. If I furnish proof that the intentional or grossly negligent details provided were not the cause of the determination of the insured event or the determination or the scope of the insurance company's liability for insurance benefits, the insurance company shall remain obliged to pay insurance benefits. The latter restriction shall not apply if the false or incomplete details were fraudulently provided by me. In case of fraudulently provided or incomplete details, the insurance company shall be released from its obligation to pay insurance benefits in all cases.

8. Declaration of assignment: I hereby assign any claims against third parties to AWP P&C S.A. at the amount of the payments made by AWP P&C S.A.

Place / Date

Signature (Minors require the signature of a parent or guardian!)

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Medical certificate

Please complete A, B or C with your personal details and booking information (inside blue frames) and submit the form to the doctor giving treatment.

A. Illness / accident of the insured person

☐ Mr ☐ Ms

First name | Surname

Date of birth | Destination / Place of event

Booking date | Commencement of journey / event | End of journey / event

Illness /diagnosis which led to the insured person's inability to travel / to participate:

Name of illness | **ICD 10 Code (Mandatory information)**

When was the diagnosis given? Date

When did the patient first see a doctor about his / her symptoms? Date

Was the patient able to travel / to participate at that time? ☐ Yes ☐ No / Not reasonable

What medication and therapy / measures were prescribed?

Any other information on treatment

Referral to a specialist physician ☐ No ☐ Yes — Name and address of the specialist physician

Was the insured person unfit for work? ☐ No ☐ Yes — from | till

Has the patient had any previous illnesses which have some connection to the present illness?

☐ No ☐ Yes — since

Please state your diagnosis for the previous illnesses | **ICD 10 Code (Mandatory information)**

If this is a chronic disease – when was the last acute episode? Date

Were you asked about whether the patient could travel / participate before the journey / event was booked? (See booking date above) ☐ No ☐ Yes

When was the first time that you were asked about patient´s ability to travel / participate? Date

Health risks

In-patient treatment ☐ No ☐ Yes — from | till

Hospital / Clinic (Name and address) ▶ **Please enclose the discharge report of the hospital.**

Name of the doctor referring patient for in-patient treatment (First name / Surname)

When was it obvious that due to health reasons the booked journey / event was no longer possible? Date

Please give reasons if this information differs to that given on the date the patient saw you for the first time:

(We reserve the right to have the data examined by the Medical Service of AWP P&C S.A.)

Place / Date | Doctor's signature | Doctor's stamp

B. Illness / accident of relatives not travelling / participating

☐ Mr ☐ Ms

First name | Surname

Date of birth

Diagnosis | **ICD 10 Code (Mandatory information)**

When did the illness / accident occur? Date

In-patient treatment ☐ No ☐ Yes from till

When did it become obvious that the patient's health required the presence of his / her relatives? Date

Place / Date | Doctor's signature | Doctor's stamp

C. Pregnancy of the insured person

First name | Surname

Date of birth | Destination / Place of event

Booking date | Commencement of journey / event | End of journey / event

When was the pregnancy ascertained and in which week of pregnancy?

Date | Week of pregnancy | Calculated date of birth

When was it first apparent that the journey / event could not be reasonably undertaken in view of the pregnancy?

Date | Week of pregnancy

What was the reason for making this decision?

Had complications already arisen by the date above? ☐ No ☐ Yes

What kind of complications were these?

In-patient treatment ☐ No ☐ Yes from till

Other reasons:

Place / Date | Doctor's signature | Doctor's stamp