Business Travel Insurance

Claim form for medical expenses etc.

Policy No

Claim No.

The claim for compensation is regarding (please tick off the box)

☐ Escort/summoning ☐ Curtailment/replacement employee ☐ Life insurance/permanent disability ☐ Ruined holiday
☐ Illness/injury ☐ Dental treatment ☐ Personal Accident ☐ Repatriation

Name of your firm | What is your job title?

First name, surname | Date of birth (CPR No.)

Street address | Postal code. | City

Email | Phone: Mobile | Home | Work

Credit card and insurance details

This information is a condition for handling your claim.

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.: Did you purchase your journey using your credit card? Yes ☐ No ☐

Is your claim reported to the credit card company? Yes ☐ No ☐ I do not have a credit card (tick off) ☐

Other insurance

In which insurance company has your firm taken out industrial injuries insurance?

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

In which insurance company have you taken out personal accident/health insurance?

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

Travel details

Date of departure | Date of return | Destination (city and country)

What is the purpose of your journey? | Airline company/travel agent

What happened?

Where and when did the claim occur? Date | Time | Location (city and country)

Description of what happened – as detailed as possible (please enclose further description)

To be filled out if you had a personal accident or was assaulted

Were there any witnesses to the incident?

Yes ☐ No ☐ Name(s) and address(es)

Has the incident been reported to the police?

Yes ☐ No ☐ If no, why not?

To be filled out if your claim is regarding curtailment

What/who was the cause of the curtailment?

How is/was the person related to you?

Documentation for the curtailment such as medical journal or death certificate and documentation for the expenses claimed must be enclosed along with your claim form.

To be filled out if your claim is regarding replacement employee

How many days were you unable to work?

Medical certificate stating diagnosis and the expected duration of the inability to work and documentation for transportation expenses must be enclosed along with your claim form.

EUROPÆISKE ERV

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Details of treatment

Treatment date | Dates of hospitalisation

Diagnosis/description of the illness

Have you previously been treated for the same illness? Yes ☐ No ☐ If yes, state the date on which you last received treatment

Were you repatriated? ☐ Yes ☐ No If yes, when?

By who? ☐ Yourself ☐ Europæiske

Your general practitioner/dentist: | Phone No.

Address | Postal code/city

To be filled out if your claim is regarding dental treatment

Did you seek dental treatment abroad?

Yes ☐ No ☐ If no, why not?

Alarm centre

Has Europæiske's alarm centre been notified about the claim? Yes ☐ No ☐ If yes, case No.

Has Europæiske's service offices (Euro-Center) been notified about the claim? Yes ☐ No ☐ If yes, case No.

Compensation claimed

Please enclose documentation		Foreign currency	DKK	Is the compensation to be paid directly to the provider? (x)
Physician's fees	Number of treatments/consultations			
Medicine prescribed by a physician				
Transport expenses				
Hospitalisation	Number of days			
Extra hotel expenses	Number of days			
Other extra expenses for illness/injury	Please specify			
Expenses for escort/summoning	Please specify			
Expenses for curtailment/replacement employee	Please specify			

How many days were you ill?

Method of payment

The compensation will be transferred to bank or giro account which belongs to ☐ Your firm ☐ You

Bank reg. No. and account No.

IBAN No. | Swift code

Name and address of the bank

Signature etc.

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, the Danish Industrial Injuries Compensation Board, Ankenævnet for Forsikring. The consent/power of attorney only covers this claim.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.

Insured's signature | Date

Signed and stamped on behalf of the firm | Date

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