Corporate 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 ☐ Ruined holiday ☐ Dental treatment
☐ Illness/injury ☐ Life insurance/permanent disability ☐ Repatriation

Name of your firm | What is your job title?

Name of Contact Person (firm) | Email of Contact Person (firm)

First name(s), surname | Date of birth

Street address | Postal code | City

Email | Phone: Mobile | Home | Work

Local insurance details

This information is a condition for handling your claim.

Please state the name of your local insurance policy

Please state the policy number of your local insurance policy

Is your claim reported to your local insurance policy? Yes ☐ No ☐

Please state the amount reimbursed by your local insurance policy

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 ERV

Your general practitioner/dentist: Name | 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 ERV's alarm centre been notified about the claim? ☐ Yes ☐ No If yes, case No.

Has Europæiske ERV'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?

Signature etc.

I hereby declare that the given information is true. I am aware that Europæiske ERV's coverage can be reduced or waived according to law, if I state untrue information.
I hereby give my consent to Europæiske ERV to collect, use and keep my personal health information and to disclose this health information to authorised persons within the health care sector, hospitals and health care institutions, public authorities, insurance companies/pension funds, The Insurance Complaints Board, Labour Market Insurance etc. The consent/power of attorney only covers this claim.
Remember that you, at any time, can withdraw your consent by contacting Europæiske ERV and stop any future use of your consent. Read more about your rights on our website at www.erv.dk under "Data Protection Policy".
Please note, that withdrawing your consent may influence our capability to process your application and that we are bound by rules and legislation regarding storing and filing of your data from the time you conclude a valid insurance contract with us.

Insured's signature

Date

Signed and stamped on behalf of the firm

Date