

# Business Travel Insurance Claim form for Cancellation

Policy No.:

Claim No.:

(Filled out by ERGO Forsikring)

<b>The claim for compensation is regarding</b>			
Name of your firm:		What is your job title?:	
First name and surname:		Date of birth (CPR No.): —	
Street address:		Phone - mobile:	Phone - home:
Postal code:	City:	E-mail:	Phone - work:
<b>Credit card and insurance details</b>			
<b>This information is a condition for handling your claim.</b>			
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.:	Is your claim reported to the credit card company?		Yes      No
I do not have a credit card	Did you purchase your journey using your credit card?		Yes      No
<b>Other insurance</b>			
Do you have another cancellation insurance? If yes,			
Company:		Policy No.:	
Is your claim reported to the insurance company?      Yes      No			
<b>Travel details</b>			
Order date:	Cancellation date:	What is the purpose of your journey?	
Planned departure:	Planned date of return:	Destination (city and country):	
<b>Reason for cancellation</b>			
When did the incident that caused the cancellation occur?			
Illness/injury	Diagnosis/description of the illness:		Death
Please state relation:      Insured      Cohabite(e)      Family, please state relation:			
<b>The patient and the patient's doctor must fill out and sign the medical certificate on the last page.</b>			
Burglary	Where?		
Fire	Where?		
Other	Please describe:		
<b>Compensation claimed</b>			
State your claim in DKK:			
How much compensation have you received from the travel agent? (please enclose original documentation):			DKK
<b>Method of payment</b>			
The compensation will be transferred to bank or giro account which belong to:		Your firm	You
Bank reg. No. and account No.:		Giro account No.:	
IBAN No.:	Swift code:		
Name and address of the bank:			

**Signature etc.**

Unused tickets and invoice from the travel agent must be enclosed along with your claim form.

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:     /     20

Signed and stamped on behalf of the firm:

Date:     /     20

# Medical Certificate

Paid by the insured

If the cause of cancellation is illness, this medical certificate must be filled out as soon as possible and sent to ERGO Forsikring.

<b>The patient's details</b>		
To be filled out if the patient is different from the insured.		
Name:	Address:	
Postal code and city:	Phone:	
<b>Consent</b>		
I hereby declare that the given information is true. I am aware that ERGO Forsikring's coverage can be reduced or waived according to law, if I state untrue information.		
I hereby give my consent to ERGO Forsikring 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, Ankenævnet for Forsikring. The consent/power of attorney only covers this claim.		
Remember that you, at any time, can withdraw your consent by contacting ERGO Forsikring and stop any future use of your consent. Read more about your rights on our website at <a href="http://www.erv.dk">www.erv.dk</a> 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.		
Patient's/insured's signature:		Date: / 20
<b>To be filled out by the patient's doctor</b>		
Patient's name:	Date of birth (CPR No.): —	
Description of illness (please state accurate diagnosis):		
Is the illness regarded as acute?      Yes      No		
If, no please answer the questions about chronic illness. Acute illness covered by the insurance is acute illness or justified suspicion of acute, serious illness.		
When did the patient show symptoms of this illness?	Date of 1st attendance:	Was the illness known when the journey was booked? Yes      No
If the illness is chronic. When did the patient develop the illness?	Has an acute aggravation occurred?      Yes      No If yes, when?	
When did you recommend cancellation due to the state of the patient's health?		
Medical comments:		
The doctor's name, address, postal code, city, phone and SE-number (if Danish doctor):		
Are you the patient's general practitioner?      Yes      No		
If no, please state name of the patient's general practitioner:		
Doctor's signature:		Date: / 20

Any expenses for the completion of this form are at the insured's expense.