

# Corporate Benefit Plan 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:
Postal code:	City:	Email:	
<b>Credit card and insurance details</b>			
What kind of credit card do you have (e.g. MasterCard, Eurocard, Globecard)?			
Is the credit card issued by a bank? <input type="checkbox"/> Danske Bank <input type="checkbox"/> Nordea <input type="checkbox"/> Other:			
Card No.:	Is your claim reported to the credit card company?		Yes <input type="checkbox"/> No <input type="checkbox"/>
I do not have a credit card <input type="checkbox"/>	Did you purchase your journey using your credit card?		Yes <input type="checkbox"/> No <input type="checkbox"/>
Do you have another cancellation insurance? If yes,			
Company:		Policy No.:	
Is your claim reported to the insurance company?    Yes <input type="checkbox"/> No <input type="checkbox"/>			
<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>Other travellers who's journey was cancelled</b>			
First name and surname:		Date of birth (CPR No.):	
First name and surname:		Date of birth (CPR No.):	
First name and surname:		Date of birth (CPR No.):	
<b>Reason for cancellation</b>			
When did the incident that caused the cancellation occur?			
<input type="checkbox"/> Illness/injury	Diagnosis/description of the illness: _____		<input type="checkbox"/> Death
Please state relation: <input type="checkbox"/> Insured <input type="checkbox"/> Cohabite(e) <input type="checkbox"/> 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>			
<input type="checkbox"/> Burglary	Where? _____		
<input type="checkbox"/> Fire	Where? _____		
<input type="checkbox"/> Other	Please describe: _____		
<b>Compensation claimed</b>			
State you claim in DKK:			
How much compensation have you received from the travel agent? (please enclose original documentation) DKK:			
<b>Method of payment</b>			
Bank reg. No. and account No.:		IBAN No.:	
Name and address of the bank:		Swift code:	

**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

# Medical certificate

Paid by the insured

This medical certificate must be filled out as soon as possible if the cause of cancellation is illness and send 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 give my consent/power of attorney to ERGO Forsikring 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, Ankenævnet for Forsikring. The consent/power of attorney only covers this claim.		
I declare that all the statements in this claims form are correct and that I have not concealed anything.		
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 <input type="checkbox"/> No <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>
If the illness is chronic. When did the patient develop the illness?	Has an acute aggravation occurred?    Yes <input type="checkbox"/> No <input type="checkbox"/> 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 <input type="checkbox"/> No <input type="checkbox"/>		
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.