AXA więcej / niż standard

Insurance Claim Form

Notification of loss under insurance of costs of cancellation of travel/airline ticket

In order to ensure that your claim is considered quickly and efficiently, please fill in this form in carefully and send it directly to the address of the company providing the loss settlement service and acting on behalf of AXA Ubezpieczenia TUiR S.A. (see below).

Please enclose the following with the form:

1. a participation agreement/confirmation of ticket or accommodation booking
2. a certificate from a travel agency containing information on how much money was refunded
3. confirmation of the carrier in the case of ticket cancellation
4. original receipts and proof of payment for return transport in the case of early return
5. documents confirming the need to cancel participation in the event (medical records, certificate issued by the police or the relevant authority)
6. confirmation by the travel agency that participation in the event was cancelled
7. a photocopy of your identity document

Contact address:

Inter Partner Assistance Polska S.A.
ul. Prosta 68
00-838 Warsaw
phone +48 22 575 90 80

A. GENERAL INFORMATION

1. **First and last name of the person filling the form** (or legal guardian)

2. Contact phone no.

3. **First and last name of the insurance holder**

4. Address

Town/City _____ Postcode ___-___ Street _____ House/Apt. No. ___/___

Contact phone no.

5. Correspondence address

Town/City _____ Postcode ___-___ Street _____ House/Apt. No. ___/___

6. E-Mail Address

Do you wish to receive letters correspondence and notifications via e-mail? ☐ Yes ☐ No

7. PESEL no.*

8. Bank account number of the Beneficiary, to whom compensation will be paid

9. Name of the bank

10. First and last name of the account holder

11. How the payment is to be made ☐ postal order (*please specify the residence address, if different from the address above*)

Town/City _____ Postcode ___-___ Street _____ House/Apt. No. ___/___

12. Policy/booking No.

13. Date and place of policy purchase (does not apply to individual policies)

14. Name of trip organiser – travel agency (concerns group policies as part of agreements with tourist trip organisers)

15. Name, phone number and address of the travel agency where the event/ticket was purchased, name of the contact person

* Applies to Polish citizens only.

16. How was the booking made/agreement signed?

☐ in person (or by others) at the travel agency
☐ online (agreement delivered by post)
☐ by phone (agreement delivered by post) ☐ by another method (how?)

17. Details of all persons who cancelled the trip:

First and last name	**Date of birth**
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y
	D D M M Y Y Y Y

B. TRAVEL INFORMATION

Date of trip/ticket booking: D D M M Y Y Y Y

Planned start date of the trip: D D M M Y Y Y Y

Planned end date of the trip: D D M M Y Y Y Y

Name of the carrier (applies to ticket cancellation)

C. LOSS INFORMATION

1. Reason for cancellation/early return

a) ☐ medical ☐ sudden illness ☐ death ☐ accident ☐ premature birth
b) ☐ damage to property ☐ burglary or robbery ☐ fire ☐ other (specify)

2. Was the incident caused by:

☐ crime ☐ suicide ☐ physical labour ☐ playing sport professionally ☐ other cause (please state)

3. **Details of the person who caused the loss under the insurance of cancellation costs.** ☐ Yes ☐ No

Is the Insured a travel companion?
Name and surname:

Is the Insured a close relative? ☐ Yes ☐ No
Name and surname

Degree of kinship (*please attach a copy of a document confirming the kinship*)

4. Date of the occurrence forcing the cancellation of the trip/early return

Date of loss: D D M M Y Y Y Y

Date of reporting the cancellation to the organiser/carrier: D D M M Y Y Y Y

a) Costs related to trip cancellation
the amount of deductions charged by the organiser/carrier
currency ___ amount ___

b) Fees for early return from the trip
cost of the return ticket
currency ___ amount ___

D. ATTACHMENTS

Confirmation of purchase of the policy or insurance from the tour operator	☐ Yes	☐ No
Contract application or airline ticket	☐ Yes	☐ No
Printed cost of cancellation/event/ticket cancellation form	☐ Yes	☐ No
Copy of death certificate	☐ Yes	☐ No
Medical form	☐ Yes	☐ No
Police report of the crime or accident	☐ Yes	☐ No

Other relevant documents ☐ Yes ☐ No

E. DECLARATIONS

I give consent to the processing by AXA Ubezpieczenia TUiR S.A., with its registered office in Warsaw (00-867) at ul. Chłodna 51 ("Insurer"), of my personal data on health and addictions provided in this form and in other documents submitted to the Insurer for the purpose of the performance of the insurance contract. The consent may be withdrawn at any time. However, its withdrawal does not affect the processing of personal data that took place before the consent was withdrawn.

☐ Yes ☐ No D D M M Y Y Y Y
Date
Signature of the Insurance Holder or his/her proxy

☐ Yes ☐ No D D M M Y Y Y Y
Date
Signature of a relative** (if the loss applies to a relative)

I declare that prior to giving the consent to the processing of my personal data on my health I received information about the principles of the processing of personal data.

☐ Yes ☐ No D D M M Y Y Y Y
Date
Signature of the Insurance Holder or his/her proxy

☐ Yes ☐ No D D M M Y Y Y Y
Date
Signature of a relative** (if the loss applies to a relative)

I agree for AXA Ubezpieczenia Towarzystwo Ubezpieczeń i Reasekuracji S.A. (hereinafter: the Insurance Company) and INTER PARTNER ASSISTANCE to ask the entities engaged in medical activities under the provisions on medical activity, that provided health services to me, for information or medical records about the circumstances related to the assessment of insurance risk and verification of the data I have provided on my health, and to establish the right to benefit under the insurance contract and the amount of the benefit.

The scope of information about health or medical records includes:

1) the cause of hospitalisation; any diagnostic tests performed at the time and their results; other provided health benefits; treatment results and prognosis; as well as the results of the autopsy, if one was carried out;
2) the cause of outpatient treatment; any diagnostic tests performed at the time and their results; other provided health benefits; treatment results and prognosis;
3) results of any consultations provided;
4) the cause of my death.

The abovementioned information shall be provided, excluding the results of DNA tests.

I agree to share the above-mentioned data and records with the Insurance Company and INTER PARTNER ASSISTANCE.

I agree to the transfer to the Insurance Company and INTER PARTNER ASSISTANCE by the National Health Fund (NFZ) of the names and addresses of service providers that have provided healthcare services in connection with an accident or chance occurrence, which are the basis for determining the Insurance Company's liability, amount of compensation, or benefit.

I authorise the Insurance Company and INTER PARTNER ASSISTANCE to obtain information from:

– the Social Security Institution, in connection with an accident or incident that is the basis for establishing the Insurance Company's liability;
– other insurance companies with whom I am or was insured, or with whom an application was submitted to conclude or join an insurance contract, to the extent necessary to assess the insurance risk, verify the details specified by the Insured, and establish the right of the Insured to receive a benefit based on an insurance contract and the benefit amount, as well as to provide the information held by the insurance companies on the Insured's death or the information necessary to establish the right of the beneficiary under the insurance contract to receive a benefit and its amount.

The above statements, authorisations and consents shall remain in force even after my death.

If you need help with completing this form, please contact: phone +48 22 575 90 80 or e-mail axa-likwidacja.szkod@ipa.com.pl

** Relative – according to the definition included in the General Terms and Conditions of Insurance.

więcej / niż standard

Medical form

Dear Doctor,
In connection with the receipt of a notification of loss under an insurance of costs of travel cancellation, please complete the form below.

Yours faithfully,
AXA Ubezpieczenia TUiR S.A. and Inter Partner Assistance Polska S.A.

1. Patient's details

First and last name

Date of birth

D D M M Y Y Y Y

Address

Town/City | Postcode | Street | House/Apt. N

2. Diagnosis of disease

3. Date of illness/accident

D D M M Y Y Y Y

4. Date of first consultation relating to the illness/accident

D D M M Y Y Y Y

5. Was the trip cancellation necessary from a medical point of view? ☐ Yes ☐ No

6. Was the patient treated for the above disease in the period preceding the date of travel booking? ☐ Yes ☐ No
If so, when?

D D M M Y Y Y Y

7. When the trip was booked, were there any medical contraindications?
If so, please specify

8. Date when the patient was notified of the need to cancel the trip D D M M Y Y Y Y

8.1. When did the first symptoms indicating that the patient would not be able to take the trip occur? D D M M Y Y Y Y

9. Contraindications preventing the patient from making the trip

10. Did the patient receive a sick note? ☐ Yes ☐ No
If so, for what period?

Locality | Date D D M M Y Y Y Y | Doctor's signature and stamp

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