Claim Reference No.:

Claim Form for Travel Accident Insurance

Please complete in full.

AWP P&C S.A., Niederlassung für Deutschland
Schadenabteilung
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Tel: +49.89.6 24 24-298 · Fax: +49.89.6 24 24-188
E-Mail: unfall-awpde@allianz.com

1. Personal details:

▶ **Please write your name in full.**

☐ Mr ☐ Ms

First name(s)

Surname(s)

Street

Street Number

Postcode

Place

Country

Profession

Telephone / Mobile

e-mail

Date of birth

2. Bank account

Who is entitled to receive the insurance benefit?

☐ see 1. **or other beneficiary:**

First name

Surname

Name of Bank

IBAN

Swift- / BIC-Code

3. Details of the insurance:

▶ **Please submit copies of your insurance certificate, the insurance confirmation with proof that the premium has been paid (receipt) and your travel confirmation.**

Booking / Travel agency / Operator (if available)

Insurance number (policy number, annual insurance number or credit card number)

Commencement of journey / stay

End of journey / stay

Period of insurance (days)

4. Details of the accident:

Place of accident

Country of accident

Date of accident

at

o´clock

Please give a brief description how the accident happened: ▶ Please use an additional sheet of paper if necessary.

What is believed to have caused the accident?

Who did you report the accident to? ▶ Please submit suitable documentation (e.g. police report, confirmation of the tour operator‘s or the like).

Police (place and address of police station, and possibly the name of contact)

▶ see reverse

Public prosecution department (place and address, and possibly the name of contact)

Tour operator's / Hotel management, Camping site management or any other office (name, address, and possibly the name of contact)

What person / witness saw the accident or saw you / the insured person first after the accident?

☐ Mr ☐ Ms First name / Surname

Address

5. Details of the injuries and initial treatment:

Please enclose findings, medical diagnoses and medical reports based on the initial treatment.

What injuries did you / the insured person suffer:

When did initial treatment begin? Date

Which doctors treated you / the insured person at the destination?

Name and address of the doctor in charge

Name and address of another doctor or specialist

Which doctor treats you / the insured person since the return from the journey?

Name(s) and address(es)

6. Details of hospital treatment:

Please submit a copy of the medical report or report on the findings / diagnosis.

In-patient treatment at a hospital at the destination? ☐ No ☐ Yes from till

Hospital / Clinic (Name and address)

Name of the doctor referring patient for in-patient treatment (First name / Surname)

In-patient treatment after the return from the journey? ☐ No ☐ Yes from till

Hospital / Clinic (Name and address)

Name of the doctor referring patient for in-patient treatment (First name / Surname)

7. Details in the event of death:

Please enclose a certificate on the cause of death and, if applicable, the autopsy report in the (respective) local language.

Date of death

Did the insured person die at the scene of the accident? ☐ No ☐ Yes

Did the insured person die during transport or in hospital? ☐ No ☐ Yes

If in a hospital: Name and address of the hospital

First name / surname of the doctor who recorded the death of the insured person

Was an autopsy carried out abroad / at the destination? ☐ No ☐ Yes

Was an autopsy carried out on domestic territory / in the home country? ☐ No ☐ Yes

Who ordered the autopsy?

Name and address

When was the insurer notified of the death?

Date

8. Details of previous accidents or pre-existing illnesses:

▶ Please enclose the medical documents and, if applicable, the declaratory certificates.

Were you / the insured person completely healthy up until the accident? ☐ No ☐ Yes

If no, please name the illnesses or consequences of previous accidents that you / the insured person suffered from previously:

1.

2.

3.

4.

Degree of impairment before the accident: %

Did / do you / the insured person receive pension payments before the accident? ☐ No ☐ Yes

If yes, please state period in which these were received:

since till

Please briefly state the reason for receiving a pension:

9. Details of further accident or life insurance:

Do you have a private accident insurance? ☐ No ☐ Yes

Insurance company (Name)

Policy number or Claim Reference number

Address of the insurance company

Do you have a life insurance? ▶ Only state in the event of death. ☐ No ☐ Yes

Insurance company (Name)

Policy number or Claim Reference number

Address of the insurance company

▶ see reverse

10. Data Protection

We process your personal data in compliance with the EU General Data Protection Regulation (GDPR), the German Federal Data Protection Act (Bundesdatenschutzgesetz, BDSG), the data protection provisions of the German Insurance Contracts Act (Versicherungsvertragsgesetz, VVG) as well as all other applicable laws. The processing of special categories of personal data – including health data – is subject to special protection. By providing us with health data in connection with your claim, you give us explicit permission to process the health data necessary for processing the claim.

11. Instructions on duty of truthfulness (Section 28 of the German Insurance Contract Act [VVG])

The above details are true and have been given to the best of my knowledge. I have noted that intentionally false or incomplete details can result in a loss of insurance benefits. If false or incomplete details are provided through gross negligence, the insurance company can reduce the insurance benefits in proportion to the degree of fault. The insurance benefits will not be reduced if I can furnish proof that false or incomplete details were not provided through gross negligence. If I furnish proof that the intentional or grossly negligent details provided were not the cause of the determination of the insured event or the determination or the scope of the insurance company's liability for insurance benefits, the insurance company shall remain obliged to pay insurance benefits. The latter restriction shall not apply if the false or incomplete details were fraudulently provided by me. In case of fraudulently provided or incomplete details, the insurance company shall be released from its obligation to pay insurance benefits in all cases.

12. Declaration of assignment: I hereby assign any claims against third parties to AWP P&C S.A. at the amount of the payments made by AWP P&C S.A.

Place / Date

Signature (Minors require the signature of a parent or guardian!)