



## Claims Form for Travel Cancellation Insurance

**Every claims application must include the following:**

1. Booking confirmation, voucher and such documents that specify date of booking, itinerary and price per person.
2. Medical Certificate from Accept completed and signed by registered and impartial medical doctor. Original document only.
3. Cancellation confirmation specifying date of cancellation as well as amount refunded, in such case, by travel agency.
4. Receipts for travel arrangements.

Insured (the invoiced)	Surname	First name	ID-number
	Address		e-mail
	Zip code	Town and country	Telephone

Co-travellers who have cancelled trip	Surname	First name	ID-number
	Surname	First name	ID-number
	Surname	First name	ID-number

Bank account for claims compensation: SWIFT och IBAN must be filled in when payment is to bank outside Sweden.

Account holder's full name	Bank	Clearing number	SWIFT/Bank nat. ID
Account number/IBAN			

**Other insurances**

Homeowners' insurance	<input type="checkbox"/> yes	<input type="checkbox"/> no	Insurance company:
Other valid/relevant insurance	<input type="checkbox"/> yes	<input type="checkbox"/> no	Insurance company:
Has the trip been paid with card?	<input type="checkbox"/> yes	<input type="checkbox"/> no	Credit card company:
Bank:	Credit card number:		
Has compensation been received from any of the above? <input type="checkbox"/> yes <input type="checkbox"/> no If yes, from which?			

**Who was affected**

Name:	ID-number:
Insured <input type="checkbox"/> Co-traveller <input type="checkbox"/> If neither, state relation to the insured:	

**Description of illness/injury**

Still undergoing treatment <input type="checkbox"/> yes <input type="checkbox"/> no	Has the affected had the same illness/injury before <input type="checkbox"/> yes <input type="checkbox"/> no
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Any additional information may be written on the back of this form or enclosed on a separate sheet.

I hereby declare that all information here provided is complete and truthful. I permit that medical doctors and other health officials, hospitals or other health institutions, the national health insurance office or other insurance establishments / insurance companies, provide Accept with such information, journals, documents of registration, certificates etc as Accept deems necessary for adjustment of this claim.

Town	Date	Signature
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Signature and declaration as above by person other than the insured who has been affected by the illness/injury.

Town	Date	Signature
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Please send to: Accept, Box 2068, SE-174 02 Sundbyberg, Sweden

