Claims Form for Travel Cancellation Insurance

Claim no. (leave blank)

Use this form to file a claim. Every claims application must include the following:

- ☐ Invoice for the travel arrangement, with specified travel dates, prices, insurances and taxes.
- ☐ Cancellation confirmation which specifies cancellation date as well as any refund made by the travel agency
- ☐ Other documents, e g visa, which may be of relevance for assessing the claim.
- ☐ Doctor's Certificate in the original, completed and signed by certified, impartial physician (for illness)
- ☐ Receipt for travel payment and, if paid by card transaction, bank account statement showing the payment.

Bank: Card number:

The insured:
(person who booked)

Name: Date of birth:

Address:

Zip code: Town and country:

E-mail: Mobile number:

How many have cancelled the trip?

☐ All those on the booking ☐ Some; how many:

Names and ages of those who cancelled:

Reason for cancelling:

Who was affected:

Name: Date of birth:

If not traveller, indicate relationship to the insured:

If sickness, is treatment still being conducted?

○ Yes
○ No

If sickness, has the affected suffered from the same illness previously?

○ Yes If yes, write date when first occurred:
○ No

Has this claim been filed/will this claim be filed with any other insurance company/travel agency/travel agent/party?:

○ Yes If yes, indicate with whom and sum:
○ No

Bank BIC: IBAN:

I hereby declare that all information provided in this claims application is in accordance with the facts. Once compensation has been received I grant Accept Försäkringsaktiebolag the authority to collect all reimbursements from other insurance companies, travel agencies, travel agents, airlines, other carriers and suppliers.

Town: Date: Siganture:

Send to:

Accept Försäkringsaktiebolag
Gustavslundsvägen 147
SE-167 51 Bromma
Sweden

or

info@accept.se

Claims adjustment including payment within 30 days of the insured's having fulfilled these obligations.

ACCEPT Försäkringar

Doctor's Certificate

To be completed and signed by physician.

Name of traveller: | Date of birth:

Name of patient (if not the same as traveller) | Date of birth:

Travel cancellation for destination

Date of booking: | Date of departure:

Place and date for exam / treatment on which this certificate is based:

Exam results and diagnosis:

ICD-10 code:

Is this a chronic illness, or one which the patient has suffered from previously?

- ○ Yes Indicate how long the patient has been symptom-free:
- ○ No

To be completed if the traveller is sick

- ○ I expressly advise the patient not to travel, since the patient's = traveller's condition is such that travel cannot be undertaken without harming the patient.
- ○ I do not advise against travel. The patient's = traveller's condition presents no obstacle to travel.

To be completed if next of kin is sick

- ○ The traveller as next of kin to the patient should not carry out the trip. This is because the patient's condition requires that special care be arranged for/provided by the traveller.
- ○ I do not advise against travel. The patient's = traveller's next of kin's condition does not need to hinder the traveller from engaging in travel.

Required information

- ○ The illness is not acute
- ○ The illness is acute
- ○ Pregnancy (n b! does not pose an obstacle to travel).
- ○ None of the above apply:

Name: | Title:

Medical stamp:

Office: | Telephone:

Place: | Date: | Signature:

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Gustavslundsvägen 147
SE-167 51 Bromma, Sweden

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