

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.

Doctor's Certificate in the original, completed and signed by certified, impartial physician (for illness)

Cancellation confirmation which specifies cancellation date as well as any refund made by the travel agency

Receipt for travel payment and, if paid by card transaction, bank account statement showing the payment.

Other documents, e.g. visa, which may be of relevance for assessing the claim.

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:

Signature:

Send to:

Accept Försäkringsaktiebolag
Box 2068
SE-174 02 Sundbyberg
Sweden

or

info@accept.se

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

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:

Office:

Telephone:

Place:

Date:

Signature:

Medical stamp: