CORPORATE BENEFIT PLAN

Policy No. _____

Claim No. _____
(Filled out by Europæiske)

CLAIM FORM FOR MEDICAL EXPENSES ECT.

The claim for compensation is regarding (please tick off the box)

☐ Escort/summoning ☐ Curtailment ☐ Life insurance/permanent disability (illness) ☐ Ruined holiday
☐ Illness/injury ☐ Dental treatment ☐ Personal accident ☐ Patient transport

Name of your firm		What is your job title?	
First name and surname		Date of birth (CPR No.)	
Street address		Phone - mobile	Phone
Postal code	City/country	Email	

Details of treatment

When did the injury/illness occur?	Dates of hospitalisation

Diagnosis/description of the illness

Have you previously been treated for the same illness?
☐ Yes ☐ No If yes, state the date on which you last received treatment _____

Treating doctor/dentist/hospital
Name _____ Tel. No. _____
Address _____ Postal code/city _____

To be filled out if you had a personal accident or assault

Where and when did the claim occur? Date Time Location (city and country)

Description of what happened – as detailed as possible (please enclose further description)

Were there any witnesses to the incident?
☐ Yes ☐ No Name(s) and address(es) _____

Has the incident been reported to the police?
☐ Yes ☐ No If no, why not? _____

To be filled out if you had curtailment

What/who was the cause of the curtailment? _____

How is/was the person related to you? _____

Please attach documentation for the curtailment such as medical journal or death certificate along with original documentation for the expenses claimed.

Alarm centre

Has Europæiske's alarm centre been notified about the claim? ☐ Yes ☐ No If yes, case No. _____

Has Europæiske's service offices (Euro-Center) been notified about the claim? ☐ Yes ☐ No If yes, case No. _____

Travel details (to be filled out if the claim occurred during travel)

Date of departure	Date of return	What is the purpose of your journey?
Destination (city and country)	Airline company/travel agent	

EUROPÆISKE REJSEFORSIKRING A/S
Frederiksberg Allé 3
DK-1790 København V
Tel. +45 33 27 82 51 (kl 9.00 - 16.00)
Fax +45 33 27 83 52 (kl 9.00 - 16.00)
cbp@er.dk
www.er.dk
CVR 62940514

Credit card and insurance details

What kind of credit card do you have (e.g. MasterCard, Eurocard, Globecard)? _____

Is the credit card issued by a bank? ☐ Danske Bank ☐ Nordea ☐ Other _____

Card No. _____ Is your claim reported to the credit card company? ☐ Yes ☐ No

I do not have a credit card ☐ Did you purchase your journey using your credit card? ☐ Yes ☐ No

Other insurance

In which insurance company have your firm taken out industrial injuries insurance?

Company _____ Policy No. _____ Is your claim reported to the insurance company? ☐ Yes ☐ No

In which insurance company have you taken out personal accident/health insurance policy?

Company _____ Policy No. _____ Is your claim reported to the insurance company? ☐ Yes ☐ No

Compensation claimed

Please enclose original documentation

		Foreign currency	DKK	Is the compensation to be paid directly to the provider? (tick off)
Physician's fees				☐
				☐
				☐
				☐
				☐
				☐
Medicine prescribed by a physician				☐
				☐
				☐
				☐
				☐
				☐
Transport expenses				☐
Hospitalisation	Number of days			☐
Extra hotel expenses	Number of days			☐
Other extra expenses for illness/injury	Please specify			☐
Expenses for escort/summoning	Please specify			☐
Expenses for curtailment	Please specify			☐

For how many days were you ill? _____

Method of payment

Bank reg. No. and account No. _____ IBAN No. _____

Name and address of the bank _____ Swift code _____

Signature etc.

I hereby give my consent/power of attorney to Europæiske to procure and forward information about the state of my health from authorised persons within the health care sector, hospitals and health care institutions, public authorities, insurance companies/pension funds, the Danish Industrial Injuries Compensation Board, Ankenævnet for Forsikring. The consent/power of attorney only covers this claim.

I declare that all the statements in this claim form are correct and that I have not concealed anything. I understand that providing incorrect information will forfeit the claim and may result in termination of the insurance.

Date / 20

Insured's signature

EUROPÆISKE REJSEFORSIKRING A/S
Frederiksberg Allé 3
DK-1790 København V
Tel. +45 33 27 82 51 (kl 9.00 - 16.00)
Fax +45 33 27 83 52 (kl 9.00 - 16.00)
cbp@er.dk
www.er.dk
CVR 62940514

EI I 182_UK_07.10