

CLAIM FORM ACCIDENT INSURANCE

CAMPING KEY EUROPE

1. Personal information

Name:		Social security number/date of birth:	
Address:			
Postal code:	City:	Country:	
Phone.no:	Mobile.no:		
e-mail:	Card.no:		

2. Account when reimbursing the claim compensation

Accountholder:	Bank:
SWIFTcode:	IBAN.no:

3. Event of claim

Date of damage:	Where did the damage occur:
Describe how the damage occurred:	
If accident – state kind /diagnosis:	
Name of the doctor and / or hospital/medical centre:	Phone.no:
Address:	
Which date did you visit the doctor or other medical caregiver:	
Is the incident reported to another insurance company? If yes, which:	Policy.no:
Additional information:	
If you have had any costs related to the accident, state which and enclose receipts in original:	
If you have used your own transportation to a medical caregiver, state the route and distance in kilometer:	

4. Signature

<i>I hereby ensure that the information I have given is comprehensive and truthful. I even authorize the doctor, hospital, other medical institutes, insurance establishment (including the social insurance office) to provide information about my health state to the insurance provider or the party handling the claim in order to assess my claim for compensation. Furthermore, I give the insurance provider or the handling party full right of disposition of any unused tickets in this matter.</i>	
Date:	Signature: