Colonnade Insurance S.A. so sídlom Rue Eugène Ruppert 20, L-2453 Luxemburg, Luxembursko,
zapísaná v Obchodnom registri Luxemburg pod č. B 61605, konajúca prostredníctvom
Colonnade Insurance S.A., pobočka poisťovne z iného členského štátu
so sídlom Štúrova 27, 042 80 Košice, IČO: 50 013 602, DIČ: 4120026471, IČ DPH: SK4120026471
zapísaná v Obchodnom registri Okresného súdu Košice I, oddiel: Po, vložka č.: 591/V

CP

*Claim notification for **Travel** insurance*

To speed up claim settlement, please answer all questions as precisely and comprehensibly as possible. The right answers should be cross-marked in the relevant square and supplementary questions should also be answered. Add any available documents. (*Turn the sheet*).

Policy No.	Validity of insurance contract From ..... To .....
Policyholder	

Insured name		Telephone No.	
Street and house number (registered office)		E-mail address	
ZIP Code/ Town/city/village		Bank account No. for claim settlement	

Country of stay		Purpose of trip .....
Way of transport		Date of exit ..... Date of return .....
Is this risk covered simultaneously by another policy?	☐ No	☐ Yes - Please specify the name and registered office of the insurer Policy No.
Have you also arranged the commercial personal accident or health insurances?	☐ No	☐ Yes - Please specify the name and registered office of the insurer Policy No.

Location of loss occurrence (address, country)			Date and hour of loss occurrence .....
Detailed description of loss occurrence and loss course			
Names and addresses of accident witnesses.	1.		2.
Was the loss investigated by the Police?	☐ No	☐ Yes - Please specify the name and address of the police unit Investigation case file No. **ORP** *(Add Police certificate of claim notification)*	
Was assistance company contacted?	☐ No	☐ Yes - Specify the date and hour of the contact	at .....:.....o'clock

Medical expenses insurance:

If the cause of the claim was a disease did the Insured suffer before the inception of the insurance cover from the disease for which he/she sought for a medical help?	☐ No	☐ - Specify since when and by what Yes	Is it a chronic disease?	☐ No ☐ Yes
If the cause of the claim was a personal accident, was it caused by another person?	☐ No	☐ - Specify the name and address: Yes		
Which healthcare facility provided the first treatment?				
What medical care or service was provided to the Insured?	☐ examination in order to determine the treatment ☐ repatriation/transfer to Slovakia or country of permanent residence ☐ repatriation of mortal remains ☐ medications, health appliances ☐ other		☐ necessary treatment ☐ hospitalization ☐ transport to hospital abroad ☐ patient escort	

Accidental insurance:

Shall the accident have permanent consequences?	☐ No ☐ Yes - Specify which ones .....
Were any of the injured parts of the body affected functionally before the accident?	☐ No ☐ Yes - Specify how .....

Baggage insurance:

Were the objects damaged before loss occurrence?	☐ No ☐ Yes - Specify how .....
Was the loss reported to the forwarder?	☐ No ☐ Yes (add the report of the baggage damaged or stolen)

	Description of Damaged, Lost or Stolen Items (in case of a larger loss add a separate list)	Purchase price [€]	Date of purchase
1			
2			
3			
4			

Liability insurance:

Was a claim made against you?	☐ No ☐ Yes - Specify the name, full address, telephone number, and e-mail address .....
Did you indemnify the Claimant?	☐ No ☐ Yes In what amount ..... € (add the evidence of payment, settlement)

Insurance of business trip cancellation, reduction or delay (baggage):

The reason of cancellation, reduction or delay of the trip (baggage)	
The time of cancellation, reduction or delay of the trip (baggage)	From ..... To .....
Costs paid previously (*for what and in what amount*)	.... €
	.... €
	.... €

List of documents and attachments submitted in respect of claim (originals)

1		4	
2		5	
3		6	

Documents submitted by:

Name and surname .....

At ..... Date .....

Signature .....

Documents received by:

Name and surname.....

Additional records

.....

.....

I declare that I answered all the questions completely and truly. I notified the policyholder of the loss and I make the claim for indemnity only once. In addition to, I authorize the Insurer to negotiate the loss with the Claimant and provided that it is in compliance with the laws to indemnify the Claimant. I agree with providing the Insurer with all necessary health documentation requested by the Insurer.

At ..... Date ....

Name and signature **of the Insured**