Claims notification
Travel indemnity insurance

To process the claim on behalf of the relevant insurer we need some further information.
We therefore ask you to complete this form, sign it and send it back to us as soon as possible. Thank you

Certificate of insurance number: _____ **(please quote in all correspondence)**

1. Policyholder:

Title:	□ Mr	□ Ms	□ Company
Surname:			
First name:			
Address:	Street:	Post code:	Town/city:
e-Mail address:			
Tel.:			
Tel. (mobile/cell):			
Fax:			

2. Person who caused the loss:

Title:	□ Mr	□ Ms	
Surname:			
First name:			
Date of birth:			
Address:	Street:	Post code:	Town/city:
Travel into / out of the country:	(please enclose appropriate evidence (copy of visa, etc.)) on:	Return scheduled for:	
e-mail address:			
Tel.:			
Tel. (mobil):			
Fax:			
Occupation/ most recent job:			

3. Person suffering the loss:

Title:	□ Mr	□ Ms	
Surname:			
First name:			
Date of birth:			
Address:	Street:	Post code:	Town/city:
Driving license:	Date of issue:	Issuing agency:	
e-mail address:			
Tel.:			
Tel. (mobile/cell):			
Fax:			
The person suffering the loss and the policyholder or person insured are connected by a	□ Family relationship, namely: □ living arrangement under the same roof	□ employment / work / other contractual relationship, namely:	
Injury:	□ yes	□ no	

4. Additional party / witness (please note any further parties/witnesses on a separate sheet):

Title:	□ Mr	□ Ms	
Surname:			
First name:			
Date of birth:			
Address:	Street:	Post code:	Town/city:
e-mail address:			
Tel.:			
Tel. (mobile/cell):			
Fax:			

Claims processing by
Care Concept AG
PO Box 30 02 62, 53182 Bonn, Germany

Tel.: + 49 228 97735-22 Fax: +49 228 97735-922 e-Mail: leistung@care-concept.de Internet: www.care-concept.de

5. Details of the accident

Date of loss/injury:	
Time:	
Where the damage/loss occured:	
Details recorded by the police: □ yes □ no	Office/station: Address: File reference:

6. Outline description/sketch: (please also enclose any photos)

7. Further details where one or more vehicles were involved:

Vehicle A		Vehicle B
	Type (e.g. car, truck, motorcycle)	
	Manufacturer	
	Model	
	Registration	
	Number year	
	Damage	
	Prior damage	
	Insured with	
	Leased vehicle	
□ yes □ no	The vehicle is a business asset	□ yes □ no
□	Vehicle was parked	□
□	Was moving off	□
□	Stopped	□
□	Was leaving a car park, property, etc.	□
□	Was turning into a car park property, etc.	□
□	Was braking	□
□	Was approaching from behind	□
□	Was travelling parallel in another lane	□
□	Changed lanes	□
□	Turned off to the right	□
□	Turned off to the left	□
□	Was overtaking	□
□	Was travelling in the opposite direction	□
□	Was reversing	□
□	Did not give way (e.g. at traffic lights)	□
□	Speed prior to collision	□
□ yes □ no	Driver under the influence of alcohol	□ yes □ no
□ yes □ no	Left the scene of the accident	□ yes □ no

8. Supplementary details

Claims have already been made:	(Please enclose correspondence) □ Yes, in the amount of EUR	□ no
I consider the claims justified:	□ Yes, because	□ no, because
Any compensation is to be paid:	□ Policyholder / account BIC: IBAN:	Claimant / account BIC: IBAN:
Entitlement to reclaim input VAT (value-added tax): :	by the policyholder □ yes □ no	By the claimant □ yes □ no

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9. Information in cases of damage to property

What was damaged?		
Nature and extent of damage:	Type (e.g. scratch, scorch mark):	Extent (e.g. scratches everywhere, small mark/stain)
The item was bought:	on approximately:	Price (approx.): EUR (enclose proof of purchase, if available)
Value of damage:	approximately.:	Repair possible: □ yes □ no (if yes, please enclose estimate)
Inspection:	An inspection was carried out by Name: Address: Tel.:	The item is available for inspection at the premises of Name: Address: Tel.:
The item was in the possession of you / your family / business employees under the following arrangement:	Rental/hire: □ yes □ no Loan…: □ yes □ no	Lease: □ yes □ no Safekeeping: □ yes □ no
Was the damage incurred by the item as a result of an activity	□ yes (e.g. repair, etc.), namely	□ no
The object is covered under another valid policy:	□ Glass □ Fire □ Mains water □ Home contents □ TPFT- □ Fully comprehensive □ Other (e.g. mobile/cell phone policy) Policy number:	with: Name: Address:

10. Details of personal injuries

Name, address, date of birth of the injured person:	Surname: First name: Date of birth:	Street: Post code: Town/city: Tel.:
Nature and extent of injury:	Nature (e.g. bruising)	Extent (e.g. all over the body)
The injured person is employed by (employer):	Surname: First name: Company (where applicable):	Street: Post code: Town/city: Tel.:
Inpatient treatment:	□ yes, from: to	□ unknown
Attending physician:	Initial treatment was undertaken by: Name: Address: Tel.:	Subsequent treatment was undertaken: Name: Address: Tel.:
Reported to a	□ yes, to name: Address: File reference:	□ no

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Important notes on the consequences of breaches of obligations following the claims event:

Cautionary guidance pursuant to Sect. 28 IV of the German Insurance Policies Act (VVG)

Dear Customer,

once the claims event has occurred, we need your help

Duty to provide information and clarification

On the basis of the matters of contractual agreement reached with you, the Insurer, represented by Care Concept AG, may require you to provide any and every item of information that is necessary in order to verify the claims event or the extent of its obligation to provide indemnity (duty to provide information) and, by means of providing all detail helpful towards clarifying the facts of the matter (duty to provide clarification), to enable it to examine its obligation to provide indemnity . The Insurer may also require you to provide it with evidence / documents where this may be reasonably demanded of you.

No obligation to provide indemnity

Where, contrary to the matters of contractual agreement, you wilfully provide false account or no account whatsoever or where you wilfully fail to provide the Insurer, represented by Care Concept AG, with the required evidence / documents, you will not forfeit your entire claim, but the Insurer may curtail its indemnity in keeping with the gravity of such failing on your part. No curtailment shall occur where you provide evidence to the effect that you have not violated the obligation through gross negligence.

Despite breach of your obligations to provide information or clarification or to procure evidence / documents, the Insurer shall nonetheless remain obliged to provide indemnity to the extent that you provide evidence to the effect that the wilful or grossly negligent breach of obligation was not causal either to ascertainment of the claims event or to the extent of the obligation to provide indemnity.

Where you are in fraudulent breach of your obligations to provide information or clarification or to procure evidence / documents, the Insurer shall in all cases be free of any obligation to provide indemnity.

End of cautionary guidance

N.B.: Where the right to contractual indemnity is the entitlement not of you, but of a third party, such third party shall likewise be obliged to provide information and clarification and to procure documentary evidence.

Final declarations

I confirm that my above statements are truthful and complete. I am aware that incorrect and / or incomplete information may result in loss of insurance cover. I have taken note of the above statements pursuant to Sect. 28 Para. 4 of VVG regarding the consequences of breaches of obligations following occurrence of the claims event.

I am aware that I am also responsible for the accuracy and completeness of details provided by me even where I have not completed this form personally.

I assign to the Insurer providing insurance cover my claims and entitlements, to the value of the indemnity provided by such Insurer, against any party causing the accident / liable party / other party under an obligation to provide indemnity.

I hereby give my consent that the insurer providing the cover and the administrator Care Concept AG may collect, store, use and transfer between them personal data pertaining to me to such extent as may be required for purposes of checking the application and of establishing, executing or terminating the insurance policies and of invoicing commission payments.

(Place, Date _____ (Signature of policyholder) _____ and (Signature insured person or his/her legal representative) _____

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