

# Baggage

## Claim Form

(Please use block letters)

Duration of trip: _____	Date of departure _____	Date of return _____	
Purpose of trip: _____	<input type="radio"/> leisure	<input type="radio"/> work	<input type="radio"/> education

### Information about the insured

First name(s) _____	Date of birth (day/month/year) _____
Family name(s) _____	Sex (M/F) <input type="checkbox"/>
Address _____	
City _____	Postal Code _____
Country _____	Tel. daytime _____
Tel. evening _____	Fax _____
E-mail _____	
Student Travel Organisation _____	
Policy number _____	

### Information about the claim

This claim is for  theft/loss  delayed baggage  other

Where did it happen? \_\_\_\_\_ Date \_\_\_\_\_ Time of the day \_\_\_\_\_

Give a full and detailed description of the event.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

*If you need extra space to give a full description, please continue on a blank piece of paper.*

Names and addresses of witnesses, if any.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### Reporting the claim

Has the claim been reported to the police/airline company/other?  Yes  No

If yes, please submit the original report.

### In case of theft

Were there any visible signs of forced entry?  Yes  No

If yes, please describe the signs.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**In case of theft from a car**Where in the car had you placed the stolen object(s)?  In the cabin  In a separate luggage compartment  OtherHas the car been damaged?  Yes  No

If yes, please describe the damage.

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Registration no. \_\_\_\_\_ Make of car \_\_\_\_\_

Insurance company \_\_\_\_\_ Car rental firm \_\_\_\_\_

**Specification of claim**

Please include all the original documentation regarding the objects. Specify the stolen objects below	When did you buy the object?	Price at the time of purchase	Value before loss/theft

**Reimbursement***Please enclose the original itemised and receipted bills and travel documentation.*The amount should be reimbursed to:  Policyholder  OtherAmount  Currency  **Please transfer reimbursement to my credit card** VISA  Eurocard / MasterCard  JCB

Card no. \_\_\_\_\_ Expiry date (m/y) \_\_\_\_\_

 **Please transfer reimbursement to my account**Name of bank Address BIC / S.W.I.F.T. Code / ABA, if any IBAN Account no. Account holder *If no choice of reimbursement method has been made, IHI will send a cheque.**Your choice of reimbursement method cannot be changed after the claim has been processed.***Information about other insurance**Do you have a similar insurance cover with another company?  Yes  No

If yes, name of company: \_\_\_\_\_ Address: \_\_\_\_\_

Policy no.: \_\_\_\_\_ Has the claim been reported to the other company?:  Yes  No**Must be signed by the insured***I, the undersigned, declare that all information given in this Claim Form is in accordance with the truth and that nothing is concealed. I authorise International Health Insurance danmark a/s (the Company) to obtain information from public authorities, travel agencies, airline companies or other organisations in order to process the claim in accordance with the Policy Conditions.**I hereby accept that the Company will record the information given for the purpose of processing data in connection with e.g. premium collection, processing of claims, reimbursements etc. In case of non acceptance of the request for reimbursement, the information given may be recorded. The Danish Act on Processing of Personal Data allows me the right of access to see documents and information recorded. Furthermore, I accept that insurance correspondence which does not contain health information or other sensible information is sent to the person registered as the policyholder.*

Date: \_\_\_\_\_ Signature: \_\_\_\_\_