CLAIM FORM

TRIP CANCELLATION

Mac users should open the claim form in Adobe Reader in order to get the full functionality.

Personal data of policyholder

First name(s) Sex (M/F)

Family name(s)

Date of birth (day/month/year) Policy number -

Address

City Postal Code

State

Country

Telephone

Mobile phone

Fax

E-mail

Travel Period

From (date/month/year) **To** (date/month/year)

Date of booking (date/month/year)

Date of purchase of trip (date/month/year)

Information about the trip

Purpose of the trip ◯ Leisure ◯ Business ◯ Combined

Nature of the trip ◯ Aeroplane ◯ Ship ◯ Bus ◯ Train ◯ Other

Travel destination

Name of travel agency

Address

City Postal Code

State

Country

Telephone

Fax

E-mail

Page 1 - Please continue on next page >

ihi Bupa ∘ Travel Sales ∘ Palaegade 8 ∘ DK-1261 Copenhagen K ∘ Denmark ∘ Tel: +45 70 20 70 48 ∘ Fax: +45 33 32 25 60 ∘ Email: travel@ihi-bupa.com ∘ www.ihi.com
24-hour emergency service ∘ Tel: +45 70 23 24 61 ∘ Email: emergency@ihi-bupa.com

CLAIM FORM

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Information regarding the claim

The claim relates to ◯ Illness ◯ Injury ◯ Death (Death certificate must be submitted)

Date of the event causing the cancellation (date/month/year)

State the person suffering the illness, injury or death

First name(s) Sex (M/F)

Family name(s)

Date of birth (day/month/year)

State your relationship to the person suffering the illness, injury or death ◯ Family member ◯ Travel companion ◯ Myself

Describe the course of the illness/injury/death

Diagnosis

Cause of death

Date of death (day/month/year)

Medical information

Please note that in order to process your claim we must receive copies of the medical statement/journal from the treating doctor and/or hospital clearly stating the reason why the patient is not fit to travel or stating cause of illness/death.

Authorisation to obtain medical information

I hereby give Bupa Denmark, filial af Bupa Insurance Limited, England, permission to seek and exchange any information from treating doctors and hospitals concerning my/our state of health as the Company deems necessary ◯ Yes ◯ No

Travel companions cancelling the same trip

Name

Address

Name

Address

Name

Address

Name

Address

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Specification of expenses – please attach copies of travel documentation

Did the travel agency, airline, etc. reimburse you part of your claim? ◯ Yes ◯ No

If no, please explain why:

Cost of the cancelled travel		Currency
Amount reimbursed by the travel agency, airline, etc.		Currency
Claim amount		Currency

Other insurance

Do you have another insurance with Bupa Insurance limited? ◯ Yes ◯ No

If yes, please indicate policy number

Do you have trip cancellation insurance cover with another insurance company or with a credit card provider? ◯ Yes ◯ No

Name of insurance Company or credit card provider

Address

City Postal Code

Country

Policy number or credit card number

Has the claim been reported under other cover? ◯ Yes ◯ No

If no, please state why:

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CLAIM FORM

TRIP CANCELLATION

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Payment method

The amount should be reimbursed to: ◯ Policyholder ◯ Other

Name

Address Postal Code

City

State

Country

If no choice of reimbursement method has been made, ihi Bupa will send a cheque.
Your choice of reimbursement method cannot be changed after the claim has been processed.

The amount should be reimbursed in the following currency ◯ USD ◯ CHF ◯ EUR ◯ GBP

◯ **Please transfer reimbursement to the following credit card**

◯ Eurocard / Mastercard ◯ Visa ◯ JCB

Name of credit card holder

Card no.

Expiry date (month/year)

◯ **Please transfer reimbursement to the following account**

Name of bank

Address

BIC / S.W.I.F.T. Code / ABA number

IBAN

Account no.

Account holder

◯ **Please send a cheque to the following address if different from page 1**

Payee

Address Postal Code

City

State

Country

Please attach following documentation

- ○ Medical report indicating reason for trip cancellation
- ○ Death certificate
- ○ Documentation of travel purchase
- ○ Copy of flight tickets

Please submit this claim form along with the attached documentation to: traveleclaim@ihi.com

If you prefer post, please print the form and send it along with the attached documentation to the address below

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