CLAIM – SNOW ASSIST & SKIPASS ASSUR

Please complete this form filling in all the blanks and LEGIBLY. Please attach any relevant documents in order to process your claim quickly.

1. Personal details

Name/Surname:_____ Address:_____

ZIP/Postal code:_____ City/ Country:_____

Phone number:_____ E-mail: _____

Mobile number:_____

2. Bank details

Account holder:_____ Bank:_____

IBAN:_____ CCP:_____

3. Information about other insurance coverage

Name and address of your obligatory insurance? _____

Policy number: _____

Have you informed this insurance about your claim? ☐ YES ☐ NO

Do you have any other complementary insurance policies? ☐ YES ☐ NO

If yes, which one? Name and address: _____

Policy number:_____

Have you informed this insurance about your claim? ☐ YES ☐ NO

4. Type of claim

- ☐ Reimbursement of the skipass
- ☐ Reimbursement of ski lessons *(Only Snow Assist Insurance)*
- ☐ Reimbursement of the hiring of ski equipment *(Only Snow Assist Insurance)*
- ☐ Search and rescue costs *(Only Snow Assist Insurance)*
- ☐ Transport costs for an ambulance and/ or a helicopter *(Only Snow Assist Insurance)*

5. Information about the claim in the case of Snow Assist insurance

Location of event:_____ Date and time: _____

Did the first aid patrol services of the ski resort intervene? ☐ YES ☐ NO If yes, how?_____

Have you been transported to a medical center? ☐ YES ☐ NO

If yes, which one and how?_____

6. Indications sur le sinistre dans le cas de l'assurance Skipass Assur

Reason for cancellation/ interruption: ☐ Illness ☐ Accident ☐ Death of the insured person

☐ Illness ☐ Accident ☐ Death of family member or close relative

☐ Partial or total closure of the ski lifts of the resort

When did you cancel or interrupt your trip?_____

Which persons were involved?

Name, Surname	Address	Connection with the insured person

Please state briefly the reason for the cancellation or interruption:

_____

_____

⇨ ***In case of cancellation, please fill this in***

If the trip was not canceled immediately, please state us the reasons why:

_____

_____

_____

⇨ ***In case of interruption, please fill this in***

In case of illness or accident, has a doctor been consulted on the spot? ☐ YES ☐ NO

Diagnosis:_____

Was hospitalisation required? ☐ YES ☐ NO If yes, on what date? _____

If you have not consulted a doctor or a hospital on-site, please state us the reasons why:

_____

_____

_____

Medical questionnaire

This questionnaire has to be completed by your attending doctor in case of a trip cancellation due to illness, accident or pregnancy. The content will be treated confidentially.

Name :	Date of birth:

Diagnosis:

Date of appearance of the first symptoms:

Date of the first consultation:

Date of the accident:

Which treatment has been prescribed?

Since when (exact date) was the patient unfit to travel?

When (exact date) was the patient fit to travel again?

On which date did the patient inform you about his/her trip?

On which date did you inform the patient that he/she was unfit to travel?

Was hospitalisation required? ☐ Yes ☐ No If yes, on what date?

Was an operation necessary? ☐ Yes ☐ No If yes, on what date?

When (exact date) did you inform the patient about his/her operation?

In case of pregnancy, when was the pregnancy confirmed?

In case of a pre-existing illness, since when has the patient been in treatment?

When was the last consultation with regard to this pathology?

Important remarks related to the trip cancellation (e.g. unexpected worsening of the patient's health):

Date :	Signature :

We reserve the right to verify this information with the Europ Assistance medical service

7. Documentation

Please send us the following documents:

- Original skipass
- Copy of medical certificates
- In the case of the Skipass Assur Insurance, the medical questionnaire attached
- In case of death, a copy of the death certificate
- All original receipts for expenses for which reimbursement is requested

7.1 Proof of the cancellation or trip interruption

- Copy of medical certificates
- Copy of the death certificate

I authorize Europ Assistance Switzerland to check and to process my data in order to settle my claims. For this, I release the doctors involved from their medical confidentiality oath towards me and authorize third parties such as travel agencies, transport companies etc. to provide any additional information. Europ Assistance is also authorized to consult official documents and to collect relevant information from the authorities and third parties.

If necessary, the data will be disclosed to third parties involved in Switzerland or abroad, in particular to co-insurers and reinsurers, for processing. However, my authorization does not require the company to pay any benefit. Europ Assistance undertakes to treat the information collected pursuant to the law on data protection.

I confirm that the information provided is truthful and complete. In addition, I am also aware of the loss of my right to the insurance benefits if my statements are false, incomplete or contradictory.

Place and date: _____ Signature: _____