Declaration of travel accident incident claim

GENERAL INFORMATION

The insurer:
Inter Partner Assistance
Avenue Louise 166/1
1050 Brussels
Tel: +32 (0)2 550 04 78
E-mail: claims-assistance@axa-assistance.com

Policyholder:
KEYTRADE BANK
Bd du Souverain 100
1170 Brussels

Holder of the KEYTRADE BANK VISA card:

Type of card: Platinum ☐ Gold ☐

Card number: _____

Surname - Forename: _____

Address: _____

_____

Phone/Mobile number: _____E-mail: _____

Refund (according to the General Conditions)

Bank account number: _____

IBAN: _____BIC: _____

Name and address of the banking institution: _____

Address (in case of financial institution abroad): _____

_____

INFORMATION ABOUT THE TRIP

Number of travellers

Surname - Forename	Surname - Forename
1.	**4.**
2.	**5.**
3.	**6.**

Trip

Date of departure: …… / …… / …… From _____ destination_____

Arrival date: …… / …… / …… From _____ destination_____

In case of interruption, number of remaining days:_____

Date of payment for the trip: …… / …… / …… Total price of the trip: _____

Cancellation/interruption costs: _____

INFORMATION ABOUT THE CLAIM

Cause(s) of the Cancellation/interruption

Identity and address of victim(s), if different from the KEYTRADE BANK VISA card holder:

_____

_____

_____

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Relationship to the insured: _____

Location and circumstances of the accident/death_____

_____

Detailed description of the circumstances

- You were a passenger on public transport or travelling in a rental car
- You were struck by a public transport vehicle
- During boarding/disembarking
- You were in the departure/arrival hall for passengers
- You were on the way back from the boarding point
- Other circumstances:

_____

_____

_____

_____

_____

Who are the possible witnesses of the accident/death_____

Surname - Forename_____

Address:_____

_____

Tel:_____ E-mail_____

Was a police report drawn up? If so, by which police force?

Name and address_____

_____

In case of repatriation of the remains/search and rescue costs

Expenses paid

Date	Providers	Amount

INFORMATION ABOUT AN EVENTUAL RECOURSE

- Possibilities of compensation and actions already undertaken:

_____

_____

- Is there a right of recovery from a third party? ☐ Yes ☐ No
- Have you taken any action yourself in this regard? ☐ Yes ☐ No

If yes, what have you done?_____

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- **Documents to attach:**
  - Copy of the invoice for the trip;
  - Name and address of the hospital;
  - Medical report (if desired, you can send the report confidentially in a sealed envelope to our doctor);
  - Police report
  - Document proving the use of a means of transport/rental car and/or accident report to the transport company
  - In case of death: a copy of the death certificate;
  - Debit notes proving that the tickets in question were purchased in full (100%) using the insured card
  - Any other document that can support your claim;
  - Tour operator's invoice showing the cancellation fees.

- **Declaration by the insured**

The undersigned declares that he or she has answered the questions correctly and that all the information given is correct. The undersigned also confirms that no information has been omitted, relating to the incident and the circumstances that caused it.

Signature of the insured Date

Please send the completed form and all the required documents:
preferably by mail to:
claims-assistance@axa-assistance.com
or by mail to:
AXA Assistance
KEYTRADE BANK VISA Card Refund Service
Av Louise 166/1
1050 Brussels

MEDICAL REPORT

To be returned by the attending physician to:

The Medical Consultant at AXA Assistance

Av. Louise, 166 - 1050 Brussels

Tel: +32 (0)2 550 04 78

E-mail: claims-assistance@axa-assistance.com

Patient: _____

Address: _____

_____

Date of birth: …… / …… / ……

1. **Detailed description of the accident that caused the interruption of the trip:**

   Examinations performed: _____

   _____

   _____

   Findings: _____

   _____

   _____

   _____

   Date of the 1st consultation: …… / …… / ……

   Expected duration of care: _____

   Nature of treatment and care: _____

   Duration and frequency: _____

   Date the patient received the 1st treatment: …… / …… / ……

   Date of the last consultation: ..... / ..... / .....

2. **Should the patient be hospitalized?**

   O No O Yes from …… / …… / …… to …… / …… / ……

3. **Should the patient be repatriated?**

   O No O Yes

4. **Can the patient leave the house?**

   O Permitted O Not permitted from …… / …… / …… to …… / …… / ……

5. **Should the activities be restricted?**

   O No O Yes from …… / …… / …… to …… / …… / ……

6. **Antecedents:**

   Medical: _____

   Surgical: _____

7. Supplementary information

Date: …… / …… / ……

Signature

Stamp

☐ **To be completed only by persons affiliated with the policy who have not yet given their explicit consent**
I confirm that I have read the conditions applicable to the processing of my personal data, including the data relating to my health, and therefore authorize the insurer to collect, store, use and transfer my data within the framework of the management of the insurance policy and the purposes defined in these data processing conditions. The insurer will treat your personal data under strict conditions of security and confidentiality. Data relating to your health will be processed only by authorized persons under the supervision of health professionals, and subject to professional secrecy.
NB:

- *A parent or legal guardian must complete this form for any beneficiary less than 18 years of age.*
- *If you do not expressly authorize processing your personal data as specified above, the insurer may not be able to process your data and thus process your refund requests.*