Trip Cancellation & Curtailment Claims Form

GENERAL INFORMATION

Insurer :
Inter Partner Assistance
Avenue Louise 166/1
B-1050 Brussels
Tel: 02 550 04 78
E-mail: Claims-assistance@ip-assistance.com

Policyholder :
KEYTRADE Bank
Bld du Souverain 100
B-1170 Brussels

KEYTRADE BANK VISA GOLD card holder:

Card number: _____

Name – First name: _____

Address: _____

_____

Telephone number / Cell phone: _____ E-mail: _____

- **Names of the insured**

Name - First name	Name - First name
1.	4.
2.	5.
3.	6.

- **Reimbursement (according to the General Terms and Conditions)**

Bank account number: _____

IBAN: _____ BIC: _____

Name of the banking institution: _____

Address (if financial institution abroad): _____

_____

INFORMATION REGARDING THE TRIP

- **Travel Agency**

Name: _____

Contact: _____

Telephone number: _____ Fax number: _____

E-mail: _____

- **Tour operator**

Name: _____ PO number: _____

Details of the cancellation insurance if this is included in the package: _____

_____

- **On-line booking tool or direct booking:**

Name website & reference: _____

_____

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- **Travel**

Reservation Date: ..... / ..... / ..... Date of Cancellation or interruption: ..... / ..... / .....

Departure date: ..... / ..... / ..... Return date: ..... / ..... / .....

In case of interruption, number of remaining days: _____

Country of destination: _____

Total price of the trip: _____

Cancellation fees: _____

INFORMATION CONCERNING THE CLAIM

- **Reason for Cancellation/Interruption**

Name of the person who is causing the cancellation/interruption:

_____

Relationship with the insured: _____

Reason for cancellation/interruption: ☐ Disease ☐ Accident ☐ Death ☐ Pregnancy

☐ Other (to clarify): _____

INFORMATION ON ANY LEGAL REGRESS

- Possibilities for compensation and actions already undertaken :

_____

_____

- Is there any legal regress towards a third party ☐ Yes ☐ No
- Have you undertaken already any action taken in that direction? ☐ Yes ☐ No

  If yes, which one? _____

- **Documents:**
  - Copy of the travel contract
  - Travel confirmation of the tour operator or on-line booking tool or direct booking;
  - Medical report (if preferred, it may be addressed confidentially and under sealed envelope to the attention of our Medical Consultant);
  - In case of death: copy of the death certificate;
  - Any other document that can justify your reimbursement;
  - The original invoice of the cancellation fees.

- **Statement by the insured**

I, the undersigned, hereby certify that I have answered all questions truly and correctly to the best of my knowledge and that I have not knowingly withheld any information with relation to this claim.

Signature of the insured Date

Please send the completed form and required documents
preferably by mail to:
Claims-assistance@ip-assistance.com
either by post to:
AXA Assistance
Claims Department KEYTRADE BANK VISA card
Avenue Louise 166/1
B-1050 Brussels

The Insurer:
Inter Partner Assistance Ltd., insurance company, registered under code 0487.
Reg. office: Av. Louise 166, PB 1, B -1050 Brussels – RPR Brussels – VAT No. BE 0415.591.055 –BIC: BBRUBEBB – IBAN: BE66 3630 8057 8243.

MEDICAL REPORT

To be sent by the attending physician to: AXA Assistance Medical Consultant Avenue Louise, 166/1- B 1050 Brussels Tel: 02/550.04.78

E-mail: Claims-assistance@ip-assistance.com

Patient: _____

Address: _____

_____

Date of birth: ..... / ..... / .....

1. **When did the incapacity to travel start:** ..... / ..... / .....

2. **Reason of the cancellation:** ☐ **Disease** ☐ **Accident** ☐ **Pregnancy**

3. **Accurate description of the disease/accident causing the cancellation/interruption:**

   Examinations performed: _____

   _____

   _____

   Date first consult: ..... / ..... / .....

   Planned duration of the treatment: _____

   Nature of medication and treatment: _____

   Duration and frequency: _____

   Date on which the patient has received his first treatment: ..... / ..... / .....

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

4. **May the patient leave his home?**

   O Allowed O Forbidden from ..... / ..... / ..... to ..... / ..... / .....

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

   O No O Yes from ..... / ..... / ..... to ..... / ..... / .....

6. **Needs the patient to be hospitalized?**

   O No O Yes from ..... / ..... / ..... to ..... / ..... / .....

7. **Date on which you have advised the insured not to undertake the planned trip:** ..... / ..... / .....

   Why? _____

   _____

   _____

   _____

   _____

8. Has the patient previously been treated for the same illness/disease?

O No O Yes from ..... / ..... / ..... to ..... / ..... / .....

If so, was the condition stabilized? O No O Yes

If yes, since when? ..... / ..... / .....

9. In the case of pregnancy

When was the pregnancy confirmed? ..... / ..... / .....

What is the due delivery date? ..... / ..... / .....

10. Antecedents:

Medical: _____

Surgical: _____

11. Additional information:

_____

_____

_____

_____

_____

Date: ..... / ..... / .....

Stamp

Signature

_____ _____

☐ I confirm that I consent to the insurer to process the data concerning my health and the health of the other insured to the extent required for the performance of the guaranteed benefits. Data concerning the health being processed under the supervision of a health care professional. A list of categories of persons who have access to this data can be consulted at Inter Partner Assistance SA, Avenue Louise 166 -1, 1050 Brussels. (Statement in accordance with Article 7 § 2, a, of the Law of December 8, 1992 regarding the protection of privacy with respect to the processing of personal data)