lalux ASSURANCES

LA LUXEMBOURGEOISE
Société Anonyme d'Assurances
9, rue Jean Fischbach
L-3372 Leudelange
R.C.S. Luxembourg B 31035

Luxair

CLAIM REPORT ACCIDENT
ILLNESS

Please complete carefully and return ASAP to:

LA LUXEMBOURGEOISE S.A. d'Assurances, L-2095 Luxembourg • Fax: +352 4761-68 68 • email: luxair@lalux.lu

RESERVATION NUMBER LUXAIR

INSURED PERSON

Name of the insured

First name of the insured

Date of birth __ / __ / ____

Place of the residence

Postal code __ – ____

Street and number

Gender
Female
Male

Profession

Phonenumber

Faxnumber

GSM

private

professionnal

E-mail address : ....

REIMBURSEMENT BY BANK TRANSFER

Bank

account Number

IBAN : ....

Account holder : ....

....

Signature of the beneficiary

NOTIFICATION: ACCIDENT OR ILLNESS

Destination : ....

Date of departure __ / __ / ____

Date of return __ / __ / ____

Place of the accident or the illness : ....

Date of occurence of the accident or the illness __ / __ / ____

ACCIDENT:

What are the exact circumstances of the accident?

....

....

....

....

....

....

Of what nature are the injuries?

....

....

....

Will there remain a permanent disability as a result of the accident?

☐ yes ☐ no

If YES, please state name and address of your treating physician:

....

....

ILLNESS:

Diagnosis:

....

....

Has the patient been suffering from this disease since a certain time?

☐ yes ☐ no

If YES, please add the enclosed medical report duly completed by your treating psysician

Additional information:

Do there exist any complementary health insurances by the social security, or another institution of foresight or rescue (e.g. Caisse médico chirurgicale mutualiste, Air rescue, credit cards, ...) and/or another Insurance Company?

Name

First name

Place of residence

Postal code

☐ – ☐☐☐☐

Street and number

Membership, Policynumber or Creditcardnumber

Name

First name

Place of residence

Postal code

☐ – ☐☐☐☐

Street and number

Membership, Policynumber or Creditcardnumber

PURPOSE OF THIS CLAIM IS THE REQUEST OF REIMBURSEMENT OF COSTS RELATED TO:

☐ Hospital costs abroad
☐ the prescription of medication
☐ a visit from a relative in case of hospitalisation abroad
☐ medical or surgical intervention
☐ transport prescribed by a physician
☐ costs for travel prolongation
☐ a rescue

I CONFIRM BY MY SIGNATURE THAT THESE STATEMENTS WERE MADE IN GOOD FAITH

.... Place and date

.... Signature of insured person preceded by «Read and approved»

TO BE ATTACHED TO THIS DECLARATION

- Original counts of the health insurance (or complementary health insurance)
- Copy of the invoices with payment confirmation
- Copies of the medical prescriptions
- Report established by local authorities (only in case of accident)
- In case of death caused by accident: Certificate of death

MEDICAL REPORT (TO COMPLETE BY YOUR TREATING PHYSICIAN)

LUXAIR Reservation number: .... Date of the Reservation: ☐☐ / ☐☐ / ☐☐☐☐

Name of the patient

First name of the patient

Place of residence

Postal code ☐ – ☐☐☐☐

Street and number

Date of birth ☐☐ / ☐☐ / ☐☐☐☐

Date of examination ☐☐ / ☐☐ / ☐☐☐☐

Exact description of the diagnosis (Nature of the disease / Symptoms):

....

....

....

1. Date of first examination: ☐☐ / ☐☐ / ☐☐☐☐
2. Treatment: ....
3. Date of last examination: ☐☐ / ☐☐ / ☐☐☐☐ Cause: ....
4. Is it a disease that the patient has been suffering already since a certain time? ☐ yes ☐ no
   - If yes, since when: ☐☐ / ☐☐ / ☐☐☐☐
   - Duration of the treatment: ....
   - Has the disease worsened? ☐ yes ☐ no
5. Would the patient have been able to travel at the reservation date (☐☐ / ☐☐ / ☐☐☐☐)? ☐ yes ☐ no
6. Was or is the patient in a hospital?
   - If yes, from ☐☐ / ☐☐ / ☐☐☐☐ to ☐☐ / ☐☐ / ☐☐☐☐
7. Has the patient been advised not to undertake or not to continue the travel? ☐ yes ☐ no
   - If yes, when? ☐☐ / ☐☐ / ☐☐☐☐
   - Why? ....

Additional remarks: ....

....

....

I HEREBY ASSIGN MY CLAIMS AGAINST MY LEGAL/PRIVATE HEALTH INSURANCE TO DKV LUXEMBOURG S.A.

....

Place and date

Seal and signature of the treating physician preceded by 'certified sincere and true'

The expenses of this medical report shall be borne by the patient.