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Allianz

VISECA payment services

Claims statement for medical travel assistance / health care costs / search and rescue costs

Please complete this claims form completely and truthfully.

Cardholder details

Claim number: _____
(if available)

Surname: _____ First name: _____

Street / no.: _____ Telephone: _____

Postcode / town: _____ E-mail: _____

Card account no.: 110 _____
(visible on the monthly statement)

Date of birth: D D M M Y Y Y Y

Card type: ☐ Basic ☐ Migros Visa Free / Cumulus ☐ Silver ☐ Gold ☐ Platinum

Credit card number: X X X X X X X X X X X X _ _ _ _

Details for payment of benefits

IBAN: _

Name and address of the account holder (if different from above):

_____

Patient details

Surname / first name: Date of birth: Relationship to the cardholder:

_____ D D M M Y Y Y Y _____

Address:

_____

Travel booking details

The trip was booked on (date): Type / purpose of the trip:

_____ _____

The reservation concerns the following service(s):

☐ Flight / train journey / boat journey Travel route (from / to): _____

☐ Hotel stay Hotel name / location: _____

☐ Rental car Rental company and location: _____

☐ Other (e.g. package) Travel service and provider: _____

Travel date (from / to): _____

Further travel booking details:

_____

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Medical travel assistance / health care costs / search and rescue costs

Due to a medical emergency during the trip:

☐ **return travel, transport or repatriation costs** have been incurred.
☐ **search and rescue costs** have been incurred.
☐ **health care costs** have been incurred.
☐ booked services were only partially used (travel interruption insurance).
☐ additional accommodation costs have been incurred (travel interruption insurance).
Type of medical emergency: ☐ Illness ☐ Accident ☐ Death

Please provide a summary of the events that led to the claim (enclose an additional sheet if necessary):

Time / place of the insured event (date / time / place / country):

Was hospitalisation necessary? ☐ Yes ☐ No
If yes, from which date (including duration):

In the case of illness: with which health insurer does the patient have basic insurance? Policy number:

Are there any supplementary insurance policies? ☐ Yes ☐ No
If yes, with which insurer? Policy number:

In the case of accident: with which accident insurer is the patient insured? Policy number:

Are there any supplementary insurance policies? ☐ Yes ☐ No
If yes, with which insurer? Policy number:

If applicable: name, address and liability insurance details
of the party responsible for the accident: Policy number:

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What damage did you incur as a result of the medical emergency? Please list the costs claimed:

Date:	Benefit:	Charged by:	Amount in CHF:

Total claim: 0,00

Accompanying persons affected by the interruption of their journey due to medical causes:

Surname / first name:	Address:	Date of birth:	Relationship to the cardholder:
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	
		D D M M Y Y Y Y	

Do you or one of these people have another travel insurance policy? ☐ Yes ☐ No

If so, who? _____

With which company (name / general agency)? Policy number:

_____ _____

Did you inform them about your case? ☐ Yes ☐ No

If so, did they assume the costs? Which ones?

_____

Mandatory enclosures:

☐ Booking confirmation

☐ Monthly statements with transactions for the booked services

☐ Other documents and/or official attestations documenting the occurrence of the loss event, receipts for expenses

Mandatory enclosures (if applicable):

☐ Copy of medical cost accounts

☐ Statement from health or accident insurer

☐ Copy of the medical report with diagnosis / death certificate

☐ Receipts for additional expenses

☐ Cancellation confirmation / invoice of cancellation costs

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Additional information, date and signature

Further relevant information about your claim statement:

The undersigned hereby confirms that the above information has been provided to the best of his / her knowledge, is truthful and complete.

IMPORTANT: The undersigned authorises Viseca Card Services SA to process the customer data required for the processing of the contract and claims (in particular personal details and the type and duration of the card contract), including all documents submitted by the insured persons, and to disclose or forward them to the respective insurer (Allianz) and Würth Financial Services AG (hereinafter referred to as WÜRTH). This occurs exclusively as part of a reported insured event for the purpose of verifying the insurance claims submitted by the cardholder. In cases in which insurance cover exists, the undersigned authorises Allianz and WÜRTH to check and process the information provided that is necessary to assess the obligation to pay benefits and to process the claim. To this end, the undersigned releases doctors from their duty of confidentiality and allows third parties, such as travel agencies, transport companies, etc., to provide further information about the trip. The undersigned is aware that their authorisation is independent of any provision of services by Allianz. Allianz and WÜRTH undertake to handle the information received in accordance with the Swiss Data Protection Act. If necessary, data will be transmitted to involved third parties in Switzerland and abroad, in particular to co-insurers and reinsurers, for data processing. Allianz and WÜRTH are also authorised to procure all pertinent information from official agencies and third parties and to inspect official files.

Our privacy notice explains how we protect your data. To read our privacy notice, please click *here*

The undersigned acknowledges that Allianz is released from its obligation to pay benefits if the insured person fraudulently attempts to deceive as regards circumstances that are relevant to the reason for or amount of the benefits after the insured event has occurred.

☐ **I hereby confirm that my details are correct and complete.**
I confirm that the above information is true and complete. I am aware that I can lose my entitlement to insured benefits if the information provided by me is untrue, incomplete or inconsistent, even if the insurer does not incur any disadvantage as a result. I agree to Allianz obtaining information and access to files from authorities (police, courts, etc.) other insurers and relevant third parties, and release the aforementioned parties from their legal or contractual duty of confidentiality. I hereby acknowledge and give my consent to information being transmitted either in full or in part to external service providers for the purpose of verifying entitlement to benefits.

☐ **Release from duty of patient confidentiality**
I am aware that Allianz checks information that I provide to substantiate my claim in order to assess its obligation to pay benefits. To this end, I hereby release doctors and their assistants mentioned in the documents I have submitted or who have been involved in the treatment from their duty of confidentiality, even after my death. However, with regard to previous treatment, this release from the duty of confidentiality shall only apply to the extent that this information is necessary for assessing the obligation to pay benefits. I also release the medical officers from Allianz from their duty of patient confidentiality vis-à-vis Allianz employees who are involved in processing the reported claim. I am aware that Allianz may make full or partial use of services provided by legally independent companies of the Allianz Group that are subject to comparable data protection standards in Switzerland or elsewhere in Europe for the purpose of processing a claim; I give my consent to the personal data concerning me or my claim, including sensitive personal data, being transferred to the aforementioned service companies for the aforementioned purpose.

Place / Date

Signature of cardholder

Please send the completed and signed form together with the required enclosures to:
claims.ch@allianz.com or AWP P&C S.A., Saint-Ouen (Paris), Wallisellen branch (Switzerland), Richtiplatz 1, CH-8304 Wallisellen