Stamp and signature of the recipient of the notification:

NOTIFICATION OF A LOSS EVENT

under insurance of medical expenses, baggage, and liability for damage caused during journeys abroad

Insurance under which indemnification is being claimed: ☐ medical expenses ☐ baggage ☐ liability for damage

INFORMATION ON THE PERSON INSURED

INSURANCE CONTRACT NUMBER:

Insurance valid from:		to:
Surname:		Given name:
Title:	Date of birth:	Personal identification number: /
Address of permanent residence in the Czech Republic / your Home State (if you do not live at this address, please provide an address for correspondence): Postcode:		
Telephone:		Email:
Name and code of health insurance company in the Czech Republic / your Home State:		

INFORMATION ON THE LOSS EVENT

(if there is not enough room for the information required, please provide it in a separate attachment)

Date of loss event:	Place:	Country:
Are you simultaneously insured for the same risk under another insurance contract (e.g. under a payment card)? If yes, specify at which company:	☐ Yes	☐ No
Have you notified the loss event to the assistance service?	☐ Yes	☐ No
Did the loss event occur under the influence of alcohol or other narcotic substances?	☐ Yes	☐ No
Has the loss event been investigated by the police? If yes, please attach the police report.	☐ Yes	☐ No
Is the damage incurred the fault of another person? If yes, please give more details:	☐ Yes	☐ No
Did the damage occur in a traffic accident? If yes, please provide the reference number:	☐ Yes	☐ No

MEDICAL EXPENSES INSURANCE

What was the illness or personal accident? Provide the diagnosis (if you know it):		
Provide a detailed description of the circumstances under which the sudden illness or personal accident occurred:		
Had you suffered from this illness before the insurance began?	☐ Yes	☐ No
Name, address and telephone number of your general practitioner in the Czech Republic / your Home State:		
Name, address and telephone number of the relevant specialist in the Czech Republic / your Home State (cardiologist, orthopaedist, internist, gynaecologist, etc.):		

I DEMONSTRATE THE AMOUNT OF DAMAGE INCURRED BY MEANS OF THESE ORIGINAL DOCUMENTS

Below, specify the amounts which you wish to be reimbursed	to the person insured	to the physician, hospital, carrier
Outpatient treatment		
Hospitalisation		
Medicinal products		
Transport		
Other		
TOTAL		

Where a box has several options, circle the applicable variant.

BAGGAGE INSURANCE

Type of damage or loss:	☐ damage	☐ destruction	☐ theft
Provide a detailed description of the circumstances under which the damage or loss occurred. In addition, provide a list of the damaged, destroyed or stolen items (if items have been damaged/destroyed, described the extent of the damage), the date of purchase and the purchase price:			

INSURANCE OF LIABILITY FOR DAMAGE CAUSED

Information on the injured party:

Surname:		Given name:
Title:	Date of birth/registration number:	Name of company (if a legal person):
Permanent residential address/Registered office:		Postcode:
Telephone:		Email:

What was the type of damage:	☐ to health	☐ to property
Provide a detailed description of the circumstances under which the damage or loss occurred:		
Are you related to the injured party?	☐ Yes	☐ No
Do you live in a shared household with the injured party?	☐ Yes	☐ No
Do you feel responsible for the damage incurred?	☐ Yes	☐ No

INFORMATION FOR THE DISPATCH OF INDEMNIFICATION

Preferred method for the dispatch of indemnification:

Postal order to the following address:		Postcode:
Bank transfer to a CZK bank account held at:		
Account number:	Bank code:	Specific symbol:

DECLARATION

I hereby declare that I have answered all of the questions truthfully and completely, that I have filled in no other notification of a loss event for the personal accident or illness I am reporting, and that I am aware of the consequences of incorrect, misleading or incomplete answers in relation to the insurer‘s obligation to provide indemnification.
I agree that the insurer may demand any and all documentation on the insured person‘s state of health and the course of treatment in order to investigate the loss event, and I absolve the physician of confidentiality. I also authorise the physician, healthcare facilities and establishments providing medical care to draw up medical reports, make extracts from medical records or to loan such documents.
In addition, I agree that, in order to investigate the boss event, the insurer may demand the necessary underlying documentation from the police, administrative authorities and other insurance companies.

I attach the following number of sheets of paper as attachments: ....

At	date
Signature of the person insured or authorised representative	

Please email the completed report to claims.travel@axa-assistance.cz,

or send it by post to AXA ASSISTANCE, Hvězdova 1689/2a, 140 00 Praha 4, Czech Republic