

Notice of claim under medical travel assistance insurance

The services provided by Visa Card Services SA in conjunction with Mastercard® Business Cards and Mastercard® Corporate Cards include **medical travel assistance insurance**. The insurance is offered through Visa Card Services SA in cooperation with insurance partners.

The claim notice is to be submitted in writing and accompanied by all the original supporting documents. Please send the completed and signed form together with the supporting documents to Visa Card Services SA, Hagenholzstrasse 56, P.O. Box 7007, 8050 Zurich.

To facilitate the proper assessment of your claim, the information provided should be as clear and complete as possible. The legally valid signatures of the cardholder and the authorised representatives of the company are required.

The following points should be observed:

- The incident must qualify as an insured event under the General Insurance Conditions (available online at www.viseca.ch/insurance-companies or by calling +41 (0)58 958 84 01).
- The entitlement to benefits is subject to the General Insurance Conditions of the respective insurer under all circumstances.
- Coverage applies to the costs remaining for medical treatment subsequent to submission to the relevant health insurance and/or accident insurance provider (excluding any franchises or excesses payable). All bills must first be submitted for reimbursement to the health insurance or accident insurance provider in question.
- To qualify for coverage under the medical travel assistance insurance, the insurer must have been contacted immediately following the insured incident (Visa Card Services SA, phone +41 (0)58 958 82 85) and the insurer's prior consent obtained for any applicable assistance measures and cost reimbursement.

Once your claim notice and all the accompanying documentation have been received by Visa Card Services SA, we will review your claim and forward it to the insurance partner responsible.

Should further information or documentation be required from you in order to process the claim, our insurance partner will contact you as quickly as possible.

Under certain circumstances, final settlement of the claim may take some time, as various clarifications have to be made. We thank you for the trust you have placed in us and we appreciate your cooperation.

Cardholder details

Last name/first name: _____ Company name: _____
Card account no.: **110** _____ Phone: _____
(as shown on your monthly bill) _____ E-mail: _____
Card type: Business Card/Corporate Card Silver Date of birth: DD MM YYYY
 Business Card/Corporate Card Gold

Patient details

Last name/first name: _____ Address: _____ Date of birth: DD MM YYYY Relationship to cardholder: _____

Details of trip booking

The trip was booked on (date): _____ Nature/purpose of trip: _____

The trip was booked with (name): _____

The reservation was for the following service(s):

Air/railway/ship travel Hotel stay
Travel route (from/to): _____ Hotel name/address: _____

Travel dates (from/to): _____ Length of stay (from/to): _____

Hire car Other (e.g. package deal)
Hire company and location: _____ Travel service and provider: _____

Hire period (from/to): _____ Travel dates (from/to): _____

Further details about the trip booking: _____

The following credit card transactions (as per the credit card bill) comprise the booked service(s):

Date:	Name/address of contractual partner:	Amount in CHF:	Amount in foreign currency:	Booked service:
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Important: Please also complete the following pages.

Medical travel assistance from Europ Assistance

Due to a medical emergency while travelling

costs for the return trip, return transport or repatriation were incurred.

search and rescue costs were incurred.

costs for medical treatment were incurred.

booked services were only partially used (trip interruption insurance).

extra costs for accommodation were incurred (trip interruption insurance).

Type of medical emergency: Serious illness Accident Death

Please describe in detail the events that led to the loss/damage (add extra pages as necessary):

Time/place of the incident (date/time/city/country):

In the case of an accident, describe the type/extent of injury:

Medical diagnosis:

Treating physician:

Date/duration of treatment:

Was hospitalisation required? Yes No

If so, as of what date (including duration of hospital stay)?

If illness: with which health insurer does the patient have basic insurance?

Policy number:

Does the patient have any supplementary cover? Yes No

If so, with which insurance provider?

Policy number:

If accident: with which accident insurance provider is the patient insured?

Policy number:

Does the patient have any supplementary cover? Yes No

If so, with which insurance provider?

Policy number:

If applicable: name, address and liability insurance of party who caused the accident:

Policy number:

Important: Please also complete the following pages.

What damage/loss was incurred due to the medical emergency? Please list all of the costs being claimed:

Date:	Service:	Invoiced by:	Amount in CHF:
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
Total claim:			_____

Fellow traveller(s) affected by the interruption of the trip for medical reasons:

Last name/first name:	Address:	Relationship to cardholder:
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Is any other travel insurance held? Yes No
 If so, please indicate the policyholder and the insurer. _____ Policy number: _____

Were the policyholder and insurer informed about the incident? Yes No
 If so, were any costs covered? Which ones?

Required documents:

- Booking confirmation
- Monthly bills showing transactions for the booked services
- Other documents or official reports/certificates confirming the occurrence of the loss/damage (e.g. police report)

Required documentation (if applicable):

- Copy of medical cost invoices
- Copy of health or accident insurance policy
- Copy of medical report including diagnosis
- Copy of death certificate

Important: Please also complete the following pages.

Additional information, company details, date and signature

Further information relevant to the insurance claim (add extra pages as necessary):

Company details

Company name: _____ Contact person: _____
Address: _____ Phone: _____
Postal code/city: _____ E-mail: _____

Bank or postal account details

Account holder: _____ At bank/post office: _____
IBAN: | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |

The undersigned hereby confirm that the information provided above is truthful, accurate and complete to the best of their knowledge.

The authorised company representatives signing hereby confirm that they have verified and approved the information provided by the claimant.

IMPORTANT: The undersigned authorise Visa Card Services SA to process the customer data required for fulfilling the contract and processing the claim (in particular, personal data and type and duration of card agreement), including all the documentation submitted by the insured person or an authorised representative of the company, and to disclose this information or forward it to the insurer, Europ Assistance (Switzerland) Insurance Ltd (hereinafter referred to as EUROP ASSISTANCE) and Würth Financial Services AG (hereinafter referred to as WÜRTH). This authorisation applies exclusively to insured events for which a claim has been submitted, for the purpose of assessing the entitlement to insurance benefits being claimed by the cardholder or an authorised representative of the company.

In cases where insurance coverage may apply, the undersigned authorise EUROP ASSISTANCE and WÜRTH to verify and process the information provided as necessary for assessing the obligation to provide indemnification and for settling the claim. For this purpose, the undersigned release physicians from their obligation of confidentiality and give their consent to third parties such as travel agents, transport companies and pension schemes to provide further information relevant to the case. The undersigned acknowledge that this authorisation is independent of any performance fulfilment on the part of EUROP ASSISTANCE. EUROP ASSISTANCE and WÜRTH undertake to treat the information received in accordance with data protection law. If necessary, information may be passed on to involved third parties, in particular to co-insurers and reinsurers, in Switzerland and abroad for data processing purposes. EUROP ASSISTANCE and WÜRTH are furthermore authorised to obtain information pertinent to the claim from official offices, authorities and third parties and to inspect official records.

The undersigned acknowledge that EUROP ASSISTANCE shall be exempted from the duty to perform if, once the insured event has occurred, the insured person or the insured company attempts to fraudulently misrepresent any circumstances that are material to the grounds for or the amount of the insurance benefits.

Important: This form is only valid if it bears the legally valid signature of the cardholder and the authorised representative of the company on the following page.

Signature(s) for the company

Last name/first name and function

Legally valid signature
(joint signature if required)

Place/date

Last name/first name and function

Legally valid signature
(joint signature if required)

Place/date

Company stamp

Signature of cardholder submitting claim

Last name/first name

Legally valid signature

Place/date