

Kindly complete this form and return it ASAP to **AXA Assurances Luxembourg** 1,place de l'Etoile L-1479 Luxembourg

Fax: (00352) 44 24 24-4506 Assurances.voyages@axa.lu

## Insurance claim – Travel cancellation /

**LUXAIR** Airline

	A complete report facilitates the processing of your claim!					
	Purpose of the claim:  ☐ Travel cancellation		LUXAIR reservation no:  Contract n°: 27/0105912- TRAVEL PACKAGE			
<u>1.</u>	Policy holder	<u>2.</u>	<b>Reimbursement</b> by bank transfer			
	Surname					
	Christian name:		Bank:			
	Date of birth: / /		IBAN account No:			
	Address:		BIC:			
	Private tel.:		Account holder:			
	Email:					
	Profession:		Signature of beneficiary:			
	Office tel.:					
	Correspondence : Please send all correspondence to the above mentioned Email address					
<u>3.</u>	Travel information					
	Destination:		Date of departure: / /			
	Date of reservation: / /		Date of return: / /			
	Date of cancellation: / /					
<u>4.</u>	Amount claimed					
	Total travel costs:€		Airport tax reimbursed by the airline?			
	Cancellation fees:€		☐ Yes ☐ Partially ☐ No			
	Amount to be reimbursed:€		Amount:€			
	Maximum 180€					
<u>5.</u>	Reason for cancellation					
	n case of sickness, accident or death please complete below the name of the affected person					
	Full name:		Profession:			
	Date of birth: / /		Office tel.:Private tel:			
	Address		Email			
Please advise the reason for cancellation by completing the appropriate section below:						

Disease:	Diagnosis:
When was the illness noticed?	
Date: / /	
When did the patient first consult a physician (due to	
this disease):	
Date: / /	
ls the patient currently at home? ☐ Yes - ☐ No	
☐ Accident:	ls a third party liable: ☐ Yes - ☐ No
Place:	Full name:
Date: / /	
Injuries:	Address:
Detailed description of the circumstances:	Name and address of his /her insurance company:
Is the patient currently at home?	His / her insurance policy no:
□ Yes - □ No	
Date of Loss://	Date of funeral:///
Other reasons (please give details):	Date of funeral:///
Date of Loss: / / /	Date of funeral: / .
Date of Loss: / /	
Date of Loss: / / /    Other reasons (please give details):  Parties affected by the travel that has been of the company of the co	Cancelled, delayed or that required an early return  Relationship to the person whose illness, accident or death lead to the cancellation, delayed departure or ear return
Date of Loss://	Cancelled, delayed or that required an early return  Relationship to the person whose illness, accident or death lead to the cancellation, delayed departure or ear return
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Date of Loss://	Relationship to the person whose illness, accident or death lead to the cancellation, delayed departure or ear return
Date of Loss://	Relationship to the person whose illness, accident or death lead to the cancellation, delayed departure or ear return  Signature of claimant preceded by "read and approved"
Date of Loss://	Relationship to the person whose illness, accident or death lead to the cancellation, delayed departure or ear return  Signature of claimant preceded by "read and approved"  Kindly provide as soon as possible, in case of:
Date of Loss: / / / /   Other reasons (please give details):   Parties affected by the travel that has been of the full name    1)   2)   3)   4)   5)   6)   6)   I hereby declare that all answers given in conjunction with this claim are true. Any intentional omission or misstatement could void AXA Assurances Luxembourg of its obligations   Signed in   , on	Relationship to the person whose illness, accident or death lead to the cancellation, delayed departure or ea return  Signature of claimant preceded by "read and approved"

- Loss: a death certificate
- Other reasons: official documents justifying the claim

## MEDICAL REPORT/

To be completed by your GP

Please send in a sealed envelope to:

AXA Assurances Luxembourg Secrétariat médical 1, place de l'Etoile L- 1479 Luxembourg

	Patient's full name:		Date of birth://			
	Address:		Date of exam: / / /			
	ason:   Disease   Accident   Pregnancy					
L.	Detailed description of diagnosis (nature of the disease and symptoms):					
2.	Date of first medical consultation: / / /					
3.						
1.						
5.	Prescribed medication:					
3.	Duration and frequency of treatment and of mo	edication:				
7.	Date of last medical consultation: / Reason					
3.	Has the patient been affected for some time by this disease? $\square$ yes $\square$ no					
	If yes, since when? / Duration has their health worsened? $\square$ yes $\square$ no	n of treatment:				
<b>)</b> .	Has the patient been advised not to undertake If yes, when? / Why?		the journey? □ yes □ no			
10.	As a consequence, has there been an interrupt	tion of their current	activities?			
		□ yes □ no	du / au / /			
L1.	Is the patient authorised to leave his home?	□ yes □ no	from / until /			
L2.	Has the patient been or will be hospitalised?	□ yes □ no	from / until /			
13.	Medical history:					
	Surgical history:					
L4.	n case of a pregnancy, estimated date of birth? / /					
15.						
			Certified true and sincere, Stamp and signature of physician			

The claimant has to assume all fees in relation with the medical consultation necessary to complete this form.

Signed in...../ ...../ ...../