DKV Luxembourg S.A.

11-13, rue Jean Fischbach
L-3372 Leudelange
T +352/42 64 64-1 | F +352/42 64 64-250
info@dkv.lu | www.dkv.lu

DKV Luxembourg
membre du Groupe lalux

DAMAGE REPORT

Travel health insurance LuxairTours

delete

Please fill in the following details carefully and return the form to:
DKV Luxembourg S.A. | 11-13, Rue Jean Fischbach | L-3372 LEUDELANGE | assistance@dkv.lu

Reservation number LuxairTours

1. Details to the current damage report

This is an application for benefits in connection with

☐ an illness at the holiday destination

☐ an early return due to illness or death of a close relative in the country of residence

☐ Others:

2. Personal details of the Person

Name | First name | Gender | Date of birth

☐ f ☐ m | DD/MM/YYYY

N° | Street

Country | Postal Code | Place | Telephone

E-Mail | Mobile phone

N° Social Security | Bank account details for the execution of reimbursement

3. Details of the trip

Date of reservation | Date of departure | Date of arrival

DD/MM/YYYY | DD/MM/YYYY | DD/MM/YYYY

Destination

4. Details in relation with the sickness/accident

Date of 1st treatment | Type of treatment

☐ outpatient ☐ inpatient

Name and address of treating physician or hospital

Inpatient treatment

from DD/MM/YYYY to DD/MM/YYYY

Description of illness/accident

Is there a connection with a previous illness?

☐ Yes ☐ No If yes, please describe the illness?

Was an extension of the initial booked travel period necessary? If so, please indicate the costs incurred under n°7

☐ Yes ☐ No If so, until wich date? DD/MM/YYYY

Did you have an accident? Date of accident Place of accident

☐ Yes ☐ No DD/MM/YYYY

Was the accident recorded by the local authorities? If yes, please state office and file number.

☐ Yes ☐ No

Was the accident caused by a third person? If so, please indicate name and address of this person

☐ Yes ☐ No

Please describe the accident

5. Details of the sick or deceased person in the country of residence (if applicable)

Name First name Gender Date of birth

☐ f ☐ m DD/MM/YYYY

N° | Street

Country Postal code Place Family relationship

Day of death (if applicable)-please add death certificate

DD/MM/YYYY

6. Supplementary informations

Is there additonal cover from a health insurance, another mutual company (e.g. CMCM) or other supplementary insurance/travel insurance?

☐ Yes ☐ No If so, which?

Address of the company

Membership or Policy number

7. Overview of the claimed costs

Please list the costs you are claiming below.

Date of invoice	Invoicing party	Billing reason	Amount	Reimbursement amount from another payer
DD/MM/YYYY				
DD/MM/YYYY				
DD/MM/YYYY				
DD/MM/YYYY				
DD/MM/YYYY				
DD/MM/YYYY				
DD/MM/YYYY				
DD/MM/YYYY				

Please add the following documents:

- Benefit statement of the statutory health insurance or another insurance company
- Copies of the invoices from doctors or hospitals or any other service providers
- Medical reports
- In the event of an accident, the official record of the local authorities
- Invoices from hotel extension/change of flight/taxi (if applicable)
- Death certificate (if applicable)

I assure that the above information has been provided truthfully and to the best of my knowledge and belief. I hereby assign to DKV Luxembourg S.A. any claims against my statutory health insurance/private insurance company.

LALUX Assurances will handle the insured's personal data in accordance with the Personal Data Protection Policy available at: https://www.lalux.lu/en/data-protection-1-1674823498/data-protection-policy

Place

Date

DD/MM/YYYY

Signature of the insured person
(for minors also signature of the legal guardian)