

REASON FOR THE CANCELLATION / BREAK OF THE TRAVEL / DELAYED DEPARTURE

Person whose disease / accident / death has caused the cancellation / delayed departure / anticipated return :

Name

First name Date of birth / /

Place of residence Postal Code -

Street and number

Profession

| | | | |
|--------------|----------------------|----------------------|----------------------|
| | Phonenumber | Faxnumber | GSM |
| private | <input type="text"/> | <input type="text"/> | <input type="text"/> |
| professional | <input type="text"/> | <input type="text"/> | <input type="text"/> |

Email address :

What was the reason for the cancellation, delayed departure, anticipated return ?

- illness** : Please add the enclosed medical certificate duly completed by your treating physician !
- accident** : Please add the enclosed medical certificate duly completed by your treating physician !

Place : Date / /

Exact description of the circumstances :

.....

.....

.....

.....

Is a third party liable ? yes no

Name of the third liable party

First name of the third liable party

Place of residence Postal Code -

Street and number

Name of the Insurance Company

Policy number

Death

Other reasons

.....

.....

.....

.....

.....

.....

PERSONS WHO HAD TO CANCEL, INTERRUPT OR DELAY THEIR TRAVEL

Name and first name

Relationship with the person whose illness, accident or death caused the cancellation, the break or the delay of the travel :

| | |
|----------|-------|
| 1) | |
| 2) | |
| 3) | |
| 4) | |
| 5) | |
| 6) | |

I confirm by my signature that the statements were made in good faith.

.....
Place and date

.....
Signature of insured person preceded by «Read and approved»

TO BE ATTACHED ASAP TO THIS DECLARATION:

- Invoice of the travel agency
- Invoice of the LUXAIR cancellation expenses
- In case of an accident or an illness : medical certificate (cf. enclosed medical certificate on next page)
- In case of death : Certificate of death
- Other reasons : official documents justifying the request

Pease complete carefully and return ASAP to:
LA LUXEMBOURGEOISE S.A. d'Assurances,
L-2095 Luxembourg • Fax : +352 4761-68 68
email : luxair@lalux.lu

MEDICAL CERTIFICATE (TO COMPLETE BY YOUR TREATING PHYSICIAN)

LUXAIR Reservation number : Date of the Reservation : / /

Name of the patient

First name of the patient

Place of residence Postal code
 -

Street and number

Date of birth
 / /

Date of medical examination
 / /

Travel from / / to / /

1. Does the patient's state of health at the time of the consultation allow him/her to undertake or continue the planned journey? yes no

2. Was the patient suffering from a chronic or pre-existing illness at the time the journey was booked? yes no

If yes, what was the patient's state of health at that time?

- it allowed the trip to be carried out.
- it was not advisable to carry out the trip.
- it was foreseeable that the patient's state of health would require medical treatment in relation to his or her illness on the day of the trip, preventing/interrupting the trip.

3. Does the illness fall under one of the following situations: yes no

- depressive state and mental or nervous illnesses which have not manifested themselves for the first time on the date of the examination.
- Voluntary termination of pregnancy not involving a medical emergency.
- Suicide or attempted suicide.
- Drunkenness or intoxication, influence of narcotics, hallucinogenic products, drugs or tranquillizers, misuse of medication or effect of medication not prescribed by an approved physician.

.....
Place and date

.....
Seal and signature of the treating physician preceded by 'certified sincere and true'

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>