COLONNADE
A FAIRFAX COMPANY

CLAIM ANNOUNCEMENT FORM
TRAVEL HEALTH INSURANCE FOR FOREIGNERS

15

Policy Number

INSURED PERSON

Name, Surname, Title

Stay/Contact Address in CZ

Zip Code

Date of Birth

Phone

E-mail

POLICYHOLDER (if different from the Insured)

Company name/ Name

Company Registration No./Date of Birth

Policy Number

STAY DETAILS

Start Date

End Date

Work stay Yes ☐ No ☐

Country of stay

LOSS DETAILS / MEDICAL EXPENSES

Illness ☐

Accident ☐

Death ☐

Preventive Care ☐

Medication ☐

Damage Liability ☐

Others ☐

Loss/Medical Expences Date

Loss/Medical Expences Time

Loss/Medical Expences Place (Address)

Loss / Medical Expenses Description

Was the loss reported to Assistance service? Yes ☐ No ☐

Claim number within Assistance service

Was the loss inspected by the police? Yes ☐ No ☐

By whom

Investigation File Number

Address/Phone/E-mail

COST COVERED BY INSURED

In case of more information, use the field „Additional information for the insurance company“.		Amount	Currency
Medical Expenses			
Medication			
Others			
Total		0.00	

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DOCTOR/HEALTHCARE FACILITY DETAILS

Where was the first treatment provided (facility address, doctor's name, date, and time of treatment)?

Where else were you treated (facility address, doctor's name, from–to dates)?

INSURANCE CLAIMS PAYMENT BANK ACCOUNT

Account Holder | B.A. Prefix | Account Number/ IBAN | Bank Code / SWIFT

Additional Information for Insurance Company

DECLARATION

I declare that I have answered all my questions truthfully and completely and that I am aware of the consequences of incorrect responses to the insurer obligation to indemnify.
I agree that Colonnade Insurance SA, the Colonnade, in accordance with Act No. 89/2012 Coll., By the Civil Code, by itself or through an authorized physician, will obtain my health status, including any medical records, from any doctor that I have been, were or will be, treated by, from a health, a health insurance company, any public authority or other insurer with whom I have contracted accident insurance. And I also authorize Colonnade to get information from these people or authorities about my health status, look into my medical records and other records of my health, get statements or copies of them. I grant this consent and authorization for the purpose of investigating claims even after my death.
For the purposes of this authorization and within its scope, I hereby release the persons and bodies mentioned above from their legal or contractual obligation of confidentiality, also within the meaning of Act No 372/2011 Coll., on Health Services.

I declare that I have arranged other travel/health insurance as well. Yes ☐ No ☐

Insurance Company | Policy Number

PERSONAL DATA PROTECTION

For further information on the processing of your personal information, including any rights you may claim in this regard, please refer to the Colonnade website under the following link: https://www.colonnade.cz/ochrana-osobnich-udaju. I further declare that I will familiarize the persons whose personal data I have provided to Colonnade with the Colonnade Privacy Policy no later than 1 month from the date of such disclosure.

NOTICE

Knowingly providing false or grossly distorted data or concealing material information when reporting damage is a criminal offense.

Date of completion of the claim report

Insured Person Signature (or Authorized Representative)

PLEASE SEND THE COMPLETED CLAIM ANNOUNCEMENT FORM TO THE E-MAIL skody@colonnade.cz.

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