Claim reporting
Trip cancellation

A complete claim makes processing easier!

Contact: Non-Auto claims service
E-mail: claims@axa.lu
Fax: (00 352) 44 24 24-8303

To be completed carefully and returned promptly to:
AXA Insurance Luxembourg
Non-Auto claims service
1, place de l'Etoile
L-1479 Luxembourg

Reason for claim: ☐ Trip cancellation - ☐ Trip delay - ☐ Trip interruption

Policy n°:

Personal data of the policyholder:

Surname:
First name:
Date of birth: ____ / ____ / _____
Address:

Personal telephone number:
E-mail:

Refund by transfer:

Account holder:
Bank:
IBAN:
BIC:
Signature:

☐ I would like any correspondence to be sent directly to me by e-mail to the address below

Cancellation fees amount:
(excluding insurance premiums)

Amount: _____ €
Other deductible amounts[1]: _____ €

Amount to be refunded: _____ €

[1]Total costs recovered:
(to be deducted from the amount to be refunded)

Airport taxes:
Hotels: _____ €
Taxis: _____ €
Other: _____ €
Total: _____ €

Trip Information:

Destination:
Departure date: ____ / ____ / _____
Return date: ____ / ____ / _____

Booking date: ____ / ____ / _____
Cancellation date: ____ / ____ / _____

Claim information:

Location of the incident giving rise to the claim:
Incident date: ____ / ____ / _____

In case of interruption or delay:

Delayed departure date: ____ / ____ / _____
Early return date: ____ / ____ / _____

Cause of cancellation, delayed departure or early return

Person whose illness, accident or death resulted in the cancellation, delayed departure or early return:

Surname and first name:
Date of birth: ____ / ____ / _____
Address:

Profession:
Work telephone number:
Private telephone number:
E-mail:

What is the cause of the cancellation, delayed departure or early return (Tick the relevant box)

☐ **Illness:**

When did the illness occur?
Date: ____ / ____ / _____
When did the patient first seek medical attention?
Date: ____ / ____ / _____
Is this person currently at home?
☐ Yes - ☐ No

Diagnosis: _____

☐ **Accident:**

Location:
Date: ____ / ____ / _____
Injuries:

Clear description of the circumstances:

Is the injured person currently at home? ☐ Yes - ☐ No

Responsible third party: ☐ Yes - ☐ No
Surname and first name:

Address:

Name and address of their insurance company:

Their policy number:

☐ **Death:**

Date of death: ____ / ____ / _____
Funeral date: ____ / ____ / _____

Cause of death:

☐ **Other cause** (specify)**:**

Participants in the trip who suffered a cancellation, delayed departure or early return

Surname and first name	Family relationship with the person whose illness, accident or death resulted in the cancellation, delayed departure or early return
1) _____	_____
2) _____	_____
3) _____	_____
4) _____	_____
5) _____	_____
6) _____	_____

The undersigned declares that he/she has answered the above questions in all honesty. An intentional omission or inaccuracy may relieve AXA Assurances Luxembourg of its obligations.

Signature of the policyholder
preceded by the mention “Read and approved”

Done at _____, on ___ / ____ / _____ _____

To be attached to this claim:
- Cancellation invoice
- In the event of illness or accident: Medical report (according to the attached form)
- In the event of death: Death certificate
- Other cause: official documents justifying the request

Medical Report

To be completed by your attending physician and sent in a closed envelope to:

AXA Assurances Luxembourg
Medical Secretariat
1, place de l'Etoile
L-1479 Luxembourg

Policy number: _____

Surname and first name of the patient:
Patient address:

Date of birth: ____ / ____ / _____

Examination date: ____ / ____ / _____

Cause: ☐ Illness - ☐ Accident - ☐ Pregnancy

1. Detailed description of the diagnosis (nature of the condition and symptoms):
_____
_____
_____

2. Date of first consultation: ____ / ____ / _____

3. Treatment: _____
_____

4. Any specialized examination? On what date(s)? _____
_____

5. Type of medication: _____

6. Duration and frequency of treatment and medication: _____

7. Date of the last consultation: ____ / ____ / _____ Reason: _____

8. Is this an illness the patient has been suffering from for some time? ☐ Yes - ☐ No
If yes: since when?: ____ / ____ / _____ Duration of treatment: _____
Has the illness got worse? ☐ Yes - ☐ No

9. Was it inadvisable to undertake the trip or to continue it? ☐ Yes - ☐ No
If yes: When? ____ / ____ / _____ Why? _____

10. Has it resulted in a disruption to everyday activities? ☐ Yes - ☐ No From ____ / ____ / _____ to ____ / ____ / _____

11. Is the patient allowed to leave their home? ☐ Yes - ☐ No From ____ / ____ / _____ to ____ / ____ / _____

12. Has the patient been hospitalised or do they need to be hospitalised? ☐ Yes - ☐ No From ____ / ____ / _____ to ____ / ____ / _____

13. Medical history: _____
Surgical history: _____

14. In case of pregnancy, expected date of delivery: ____ / ____ / _____

15. Other comments: _____
_____

The invoice relating to this questionnaire is payable by the insured.

Certified sincere and genuine;
Attending physician's stamp and signature:

Done at _____

____ / ____ / _____