KEYTRADE BANK

AXA ASSISTANCE redefining / service

Declaration of an incident involving interruption or cancellation of travel

GENERAL INFORMATION

The insurer:
Inter Partner Assistance
Avenue Louise 166/1
1050 Brussels
Tel: +32 (0)2 550 04 78
E-mail: claims-assistance@axa-assistance.com

Policyholder:
KEYTRADE BANK
Bd du Souverain 100
1170 Brussels

Holder of the KEYTRADE BANK VISA card:

Card type Platinum ☐ Gold ☐

Card number: ______________________________

Surname - Forename: ______________________________

Address: ______________________________

____

Phone/Mobile number: ______________ E-mail: ______________

- **Names of the insured person(s)**

Surname - Forename	Surname - Forename
1.	4.
2.	5.
3.	6.

- **Refund (according to the General Conditions)**

Bank account number: ______________________________

IBAN: ______________ BIC: ______________

Name and address of the banking institution: ______________________________

Address (in case of financial institution abroad): ______________________________

____

INFORMATION ABOUT THE TRIP

- **Travel agency**

Name: ______________________________

Contact person: ______________________________

Telephone number: ______________ Fax: ______________

E-mail: ______________________________

- **Tour operator**

Name: ______________ PO number: ______________

Details of the cancellation insurance if included in the travel plan: ______________

____

- **Online booking site or direct booking:**

Name of the website & reference: ______________________________

KEYTRADE BANK

AXA ASSISTANCE redefining / service

Declaration of an incident involving interruption or cancellation of travel

- **Trip**

Date of reservation: ...... / ...... / ...... Date of cancellation or interruption: ...... / ...... / ......

Date of departure: ...... / ...... / ...... Arrival date: ...... / ...... / ......

In case of interruption, number of remaining days:______________________________

Destination: ______________________________

Total price of the trip: ______________________________

Cancellation fees: ______________________________

INFORMATION ABOUT THE CLAIM

- **Cause(s) of the Cancellation/interruption**

Name of the person who originally made the cancellation / interruption request necessary:

____

Relationship to the insured: ______________________________

Cause of the cancellation/interruption: ☐ Illness ☐ Accident ☐ Death ☐ Pregnancy

☐ Other (to be specified): ______________________________

INFORMATION ABOUT AN EVENTUAL RECOURSE

- Possibilities of compensation and actions already undertaken:

____

____

- Is there a right of recovery from a third party? ☐ Yes ☐ No
- Have you taken any action yourself in this regard? ☐ Yes ☐ No

If yes, what have you done?______________________________

- **Documents to attach:**
  - Copy of the travel contract
  - Confirmation of travel by the tour operator or an online or direct booking;
  - Medical report (if desired, you can send the report confidentially in a sealed envelope to our doctor);
  - In case of death: a copy of the death certificate;
  - Debit notes proving that the tickets in question were purchased in full (100%) using the insured card
  - Any other document that can support your claim;
  - Tour operator's invoice showing the cancellation fees.

- **Declaration by the insured**

The undersigned declares that he or she has answered the questions correctly and that all the information given is correct. The undersigned also confirms that no information has been omitted, relating to the incident and the circumstances that caused it.

Signature of the insured Date

Please send the completed form and all the required documents:
preferably by mail to:
claims-assistance@axa-assistance.com
or by mail to:
AXA Assistance
KEYTRADE BANK VISA Card Refund Service
Av Louise 166
1050 Brussels

The insurer:
Inter Partner Assistance SA, insurance company registered under number 0487
Registered office: Avenue Louise 166, 1050 Brussels - RLP Brussels - VAT BE 0415.591.055. BIC BBRUBEBB – IBAN BE66 3630 8057 8243

KEYTRADE BANK

AXA ASSISTANCE
redefining / service

Declaration of an incident involving interruption or cancellation of travel

MEDICAL REPORT

To be returned by the attending physician to:

The Medical Consultant at AXA Assistance

Av. Louise, 166/1 - B 1050 Brussels

Tel: +32 (0)2 550 04 78

E-mail: claims-assistance@axa-assistance.com

Patient: ______________________________

Address: ______________________________

____

Date of birth: …… / …… / ……

1. **Date the inability to travel arose:** ...... / ...... / ......

2. **Reason for cancellation:** ☐ Disease ☐ Accident ☐ Pregnancy

3. **Detailed description of the condition/accident that caused the cancellation/interruption:**

   Examinations performed: ______________________________

   ____

   ____

   Date of the 1st consultation: …… / …… / ……

   Expected duration of care: ______________________________

   Nature of treatment and care: ______________________________

   Duration and frequency: ______________________________

   Date the patient received the 1st treatment: …… / …… / ……

   Date of the last consultation: ...... / ...... / ......

4. **Can the patient leave the house?**

   O Permitted O Not permitted from …… / …… / …… to …… / …… / ……

5. **Should the activities be restricted?**

   O No O Yes from …… / …… / …… to …… / …… / ……

6. **Should the patient be hospitalized?**

   O No O Yes from …… / …… / …… to …… / …… / ……

7. **Date on which you advised the insured against taking the trip:** ...... / ...... / ......

Why? ______________________________

____

____

____

KEYTRADE BANK

AXA ASSISTANCE redefining / service

Declaration of an incident involving interruption or cancellation of travel

8. Has the patient received treatment previously for the same condition?

O No O Yes from …… / …… / …… to …… / …… / ……

If yes, was the condition stabilized? O NoO Yes

If yes, since when? ...... / ...... / ......

9. In case of pregnancy

Date at which pregnancy was diagnosed? ...... / ...... / ......

When is the birth expected? ...... / ...... / ......

10. Antecedents:

Medical: ______________________________

Surgical: ______________________________

11. Supplementary information

____

____

____

____

____

Date: …… / …… / …… Signature

Stamp

______________________ ______________________

☐ **To be completed only by persons affiliated with the policy who have not yet given their explicit consent**
I confirm that I have read the conditions applicable to the processing of my personal data, including the data relating to my health, and therefore authorize the insurer to collect, store, use and transfer my data within the framework of the management of the insurance policy and the purposes defined in these data processing conditions. The insurer will treat your personal data under strict conditions of security and confidentiality. Data relating to your health will be processed only by authorized persons under the supervision of health professionals, and subject to professional secrecy.
NB:

- *A parent or legal guardian must complete this form for any beneficiary less than 18 years of age.*
- *If you do not expressly authorize processing your personal data as specified above, the insurer may not be able to process your data and thus process your refund requests.*

Declaration of an incident involving interruption or cancellation of travel