

Claim Form: Travel Cancellation and Interruption

GENERAL INFORMATION

Insurer:

Inter Partner Assistance NV – Belgian branch
Regentlaan 7
B-1000 Brussels
Telephone number: 02 550 04 78
Email: claims-assistance@axa-assistance.com

Policyholder:

KEYTRADE BANK
Vorstlaan 100
B-1170 Brussels

KEYTRADE BANK VISA GOLD cardholder:

Card type ☐ Platinum ☐ Gold ☐
Card number: _____
Surname - First name: _____
Address: _____

Telephone number / Mobile: _____ Email: _____

Names of the insured persons

Surname - First name		Surname - First name	
1.		4.	
2.		5.	
3.		6.	

Refunds (in accordance with the Terms and Conditions)

Bank account number: _____
IBAN: _____ BIC: _____
Name of the bank: _____
Address (if the financial institution is abroad): _____

TRAVEL INFORMATION

Travel agency

Name: _____
Contact person: _____
Telephone number: _____ Fax number: _____
Email: _____

Tour operator

Name: _____ PO number: _____
Details of the cancellation insurance, if included in the trip _____

Online booking tool or direct booking:

Website name & reference: _____

The insurer:**Inter Partner Assistance NV – Belgian branch**

Regentlaan 7 - 1000 Brussels - Belgium - IBAN: BE49 3100 7270 0071 - BIC: BBRUBEBB - BE 0415.591.055 - Brussels Trade Register.
French insurer authorised by the ACPR and with its registered office at 8-10 Rue Paul Vaillant Couturier, 92240 Malakoff, France, with company number 316139500 (RCS Nanterre).

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- Trip**

Booking date: / /

Cancellation – interruption date: / /

Departure date: / /

Return date: / /

If the trip is interrupted, number of remaining days:

Country of destination:

Total price of the trip:

Cancellation fees:

DETAILS REGARDING THE CLAIM

- Reason for cancellation / interruption**

Name of the person involved who is the cause of the cancellation / interruption:

Relationship to the insured person:

Reason for cancellation/interruption: ☐ Illness ☐ Accident ☐ Death ☐ Pregnancy

☐ Other (please specify):

INFORMATION REGARDING ANY RIGHT OF RECOURSE

- Possibilities for compensation and actions already taken:

.....

Is there a right of recourse against a third party? ☐ Yes ☐ No

Have you already taken any action in this regard? ☐ Yes ☐ No

If so, what steps?

- Documents to be attached:**

- Copy of the travel contract
- Travel confirmation from the tour operator, online booking platform or direct booking;
- Medical report (if desired, this may be sent in a sealed envelope marked 'Confidential' for the attention of our medical officer);
- In the event of death: a copy of the death certificate;
- A copy of the insured person's bank statement or direct debit notification showing that 75% of the cost of the trip was paid using the insured card;
- Any other document supporting your claim for reimbursement;
- The original invoice for the cancellation fees

- Statement by the insured person**

The undersigned declares that they have answered the questions to the best of their ability, accurately and truthfully, and have not withheld any details relating to this claim

Signature of the insured person

Date

Please send this completed form and the necessary documents:

preferably by email to:

claims-assistance@axa-assistance.com or

by post to:

AXA Assistance

KEYTRADE BANK VISA Card Refunds Department

Regentlaan 7

B-1000 Brussels

The insurer:

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BE-KEY-CLAIM-EN-CANCEL_07092026

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MEDICAL REPORT

To be sent by the attending doctor to: the medical
adviser at AXA Assistance, Regentlaan 7 – B 1000

Brussels

Tel: 02/550.04.78

Email: claims-assistance@axa-assistance.com

Patient: _____

Address: _____

Date of birth: / /

1. Date from which the inability to travel has existed: / /

2. Reason for cancellation: ☐ Illness ☐ Accident ☐ Pregnancy

3. Detailed description of the illness/accident that caused the cancellation

/interruption:

Tests carried out: _____

Date of first consultation: / /

Expected duration of treatment: _____

Nature of medication and treatment: _____

Duration and frequency: _____

Date on which the patient first received treatment for the condition: / / Date of last
consultation: / /

4. Is the patient permitted to leave the house?

☐ Permitted ☐ Prohibited from / / to / /

5. Should activities be suspended?

☐ No ☐ Yes, from / / to / /

6. Does the patient need to be admitted to hospital?

☐ No ☐ Yes, from / / to / /

7. Date on which you advised the insured traveller against undertaking the planned journey:

..... / /

Why? _____

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8. Had the patient previously been receiving treatment for the same condition?

Oh no O Yes, from / / to / /
..... If so, had the condition stabilised? O No O
Yes If so, since when? / /

9. In the event of pregnancy

When was the pregnancy confirmed? / / What is the
expected date of delivery? / /

10. Medical history:

Medical: _____
Surgical: _____

11. Additional information:

Date: / /

Signature

Stamp

☐ **To be completed only by persons covered by this policy who have not yet given their explicit consent.**

I confirm that I have read and understood the terms and conditions governing the processing of my personal data, including data relating to my health, and that I have given the insurer consent to collect, store, use and disclose my data for the purposes of managing the insurance policy and in accordance with the purposes set out in these processing terms and conditions. The insurer will handle your personal data under strict security and confidentiality conditions. Data relating to your health will be processed exclusively by specially authorised persons working under the supervision of medical professionals who are bound by professional confidentiality.

NB:

- *A parent or legal guardian must complete this form for each beneficiary under the age of 18.*
- *If you do not give your explicit consent to the processing of your personal data as set out above, the insurer may not be able to process your data or handle your claims for reimbursement.*

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