

# Travel Insurance Indemnity Application (trip cancellation, illness, accident)



(please complete in UPPERCASE)

<b>Insurance contract</b>	Policy number	Date of validation	Date of expiry	
<b>Policyholder</b>  (Person who concluded the contract and pays for insurance)	First name and surname / Company name		Personal identification code / Registry code	
	Mailing address (street, building, city, municipality, county, postcode)			
	Phone	E-mail	Fax	
<b>Insured person</b>	First name and surname		Personal identification code	
	Mailing address (street, building, city, municipality, county, postcode)			
	Phone	E-mail	Occupation	
<b>Indemnity receiver</b>	First name and surname / Company name		Personal identification code / Registry code	
	Bank account no		Bank	
<b>Trip</b>	Type of trip	<input type="checkbox"/> vacation <input type="checkbox"/> business trip <input type="checkbox"/> other .....		
	Description of the route of trip (destinations, date, time)			
	Planned trip			
	Actual trip			
<b>Event</b>  Have You concluded a similar contract at another insurance company? <input type="checkbox"/> no <input type="checkbox"/> yes, please specify ..... .....	Country	Place	Date / Time	
	<input type="checkbox"/> <b>Trip cancellation</b>	<input type="checkbox"/> Cancellation of trip	<input type="checkbox"/> Delay of trip	<input type="checkbox"/> Interruption of trip
		<input type="checkbox"/> <b>Illness/ accident</b>	Time of first aid	Time of ambulatory treatment
	<input type="checkbox"/> illness appeared for the first time during the trip <input type="checkbox"/> illness was diagnosed before the trip <input type="checkbox"/> I have suffered from similar illness before (please specify) .....			
	Were You under the influence of alcohol or drugs during the time the accident happened? <input type="checkbox"/> no <input type="checkbox"/> yes			
	Have You contacted SOS International? <input type="checkbox"/> no <input type="checkbox"/> yes			

	<p>Detailed description of what happened</p> <p style="text-align: right;"><i>If necessary, use an additional page.</i></p>
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<p><b>Amount of loss</b></p> <p>Please add concerning every expense:</p> <p>1) document certifying the expense (original bills and tickets)</p> <p>2) document certifying the payment (purchase checks, bank extracts etc.)</p>	<p>Where is the event registered? Add a certificate from appropriate facility. Doctor's statement must include a diagnosis.</p> <p><input type="checkbox"/> Medical facility   <input type="checkbox"/> Airline company   <input type="checkbox"/> Police   <input type="checkbox"/> Other facility .....</p>		
	<p>Have You received indemnifications/repayments concerning the event?   <input type="checkbox"/> no   <input type="checkbox"/> yes, from who and how much</p>		
	Name of expense	Explanation of expense	Sum in currency (unit)
	Doctor's appointment		
	Medicaments		
	Expense of cancelled trip from which received repayments have been deducted		
	Additional expense on accommodation		
	Additional travelling expense		
Other expenses			
Sum in EUR			

<p><b>Added to indemnity application</b></p>	<p>Documents certifying expenses</p> <p><input type="checkbox"/> documents certifying expenses ..... pcs</p> <p><input type="checkbox"/> documents certifying payments ..... pcs</p> <p><input type="checkbox"/> documents certifying repayment ..... pcs</p>
	<p>Documents certifying the event</p> <p><input type="checkbox"/> doctor's statement ..... pcs</p> <p><input type="checkbox"/> certification of incapacity for work ..... pcs</p> <p><input type="checkbox"/> certification of transportation company ..... pcs</p> <p><input type="checkbox"/> copy of indemnity receiver's personal identification document (copy of a B-card for a company) if the indemnity exceeds EUR 6,400 or the indemnity receiver is not the person insured</p> <p><input type="checkbox"/> other documents ..... pcs (please specify)</p>

<p><b>Notes</b></p>	
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<p><b>Insured person</b> (legal representative)</p>	<p>I confirm that the details given above are true. I hereby consent Seesam to process personal data (including delicate personal data) and obtain information and data in regard to the aforementioned accident from relevant persons (e.g. medical institutions, attending physicians).</p>		
	<p>First name and surname</p>	<p>Date</p>	<p>Signature</p>

<p><b>Insurance company</b></p>	<p>Seesam Insurance AS, A.H.Tammsaare tee 118d, 12918 Tallinn, Phone +372 628 1700, Fax +372 628 1771, e-mail <a href="mailto:kahjud@seesam.ee">kahjud@seesam.ee</a>, <a href="http://www.seesam.ee">www.seesam.ee</a></p>
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<p><b>Registration of application</b></p>	<p>Name of Seesam's representative who received the application</p>	<p>Date</p>	<p>Signature</p>
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