claim form [CCAP]

erika travel insurance

PROGRAM NAME

☐ Cultural Care Au Pair, Basic Insurance
☐ Cultural Care Au Pair, Extended Insurance
☐ Cultural Care Au Pair, Additional Month
☐ Second Year, Basic
☐ Second Year, Extended

PERSONAL INFORMATION

First Name | Last Name | Date of Birth (Year / Month / Day)

Address in home country

Street | City | Zip Code | Country

E-mail address (only if the claims agent can contact you by e-mail) | Phone number in home country (incl. area code)

Address in host country (host family or school)

Name | Street | Zip Code

City | State/Province | Country | Phone number in host country (incl. area code)

Erika Policy Number (printed on your Erika Travel Insurance Card) | CCAP Booking Number

Start date of Cultural Care Au Pair program (date of departure) (Year / Month / Day) | End date of Cultural Care Au Pair program (Year / Month / Day)

What other insurance do you have?

Type of insurance | Name of insurance company

BANK DETAILS

(Please enter your bank details from your home country so we can reimburse you by wire transfer. Without these completed bank details, no payment can be made. If you are in the US and have more than 6 weeks left of your program, and want the refund in the US, you do not have to fill out the bank details. The refund will be sent via check to your US address.)

Account holder's name

Bank name | Bank address

Account number

IBAN (You must contact your bank to get the 18-30 character IBAN number starting with the two character country code. Example: DE12 3456 7890 1234 5678 00)

SWIFT/BIC code (You must contact your bank to get the SWIFT, example: BNPAFRPPCAN, or BIC number, example: CSQU1234567)

ILLNESS OR ACCIDENT CLAIM

☐ Illness ☐ Car Accident ☐ Other Accident

Date of accident or date illness began (Year / Month / Day) | Date of first visit to the doctor or hospital (Year / Month / Day)

Describe your illness or accident with as many details as possible, including where and how it occurred (add a separate paper, if needed)

Doctor currently treating you

Name | Phone number

Have you seen a doctor for the same illness or condition in your home country?

☐ Yes ☐ No | If yes, when? | Doctor's name | Phone number

COSTS FOR TREATMENT

(Attach original bills, receipts and reports with diagnosis)

Type of cost (doctor's visit, medicine etc.)	Amount and currency	Who paid the bill? *

*) Payment will be made to your doctor or hospital, unless paid receipts are attached to this claim form.

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PROPERTY/BAGGAGE CLAIM

Type of damage or loss

Describe what happened with as many details as possible (please add a separate paper, if needed)

Where and when did the damage or loss occur?

City | Country | Year | Month | Day

Where were you when the damage or loss occured?

Where was the property kept at the moment of damage or loss (e.g on your person, in your room, etc.)?

Was the room in question locked? ☐ Yes ☐ No | Where was the key?

Was the storage (suitcase, bag, cupboard, etc.) in question locked? ☐ Yes ☐ No | Where was the key?

SPECIFICATION OF DAMAGED OR LOST PROPERTY

(Attach police report, report from airline, receipts or other proof of ownership of valuable property)

Detailed description of damaged or lost property (please add a separate paper, if needed)	Purchase price and currency	Date of purchase	Claim for compensation
			Total amount

OTHER TYPE OF CLAIM

Please give details (add a separate paper, if needed)

SIGNATURE

I hereby certify that the above statements are true and accurate to the best of my knowledge.

» *I hereby authorize those doctors, who are now or have been giving me treatment, as well as my insurer, social insurance office or similar, where I am or have been covered under a personal accident or medical insurance, to supply the insurance company and their claims agent with all the information required on my state of health for considering my claim. I also give my consent to data processing the relevant information.*

» *If, in the event of property loss or theft, even after compensation has been paid, the property is returned to me, or I acquire knowledge of its whereabouts, I promise to notify the insurance company immediately.*

» *I additionally authorize Erika Travel Insurance and their claims agents to claim from the National Social Insurance Office, on my behalf, compensation for medical expenses in the EU/EES, and other countries.*

Authorization for the release of personal health information: In the event of an accident, illness or injury, I hereby authorize Erika Travel Insurance, their claim agents, representatives and employees and all physicians, hospitals, medical service providers, insurance companies, employers, law enforcement agencies and any other agent or organization to release all of my personal health information, including the history obtained, X-ray and physical findings, treatments, diagnosis, and prognosis. I understand this authorization may be revoked by written notice to Erika Travel Insurance, but this will not apply to information already released. I also agree a photographic copy of this authorization shall be as valid as the original. I understand that this authorization is voluntary and that information redisclosed will no longer be protected by federal privacy regulations. This authorization will expire one year from the date you sign this authorization.

Date | Signature

AS A LAST CHECK:

☐ All relevant documents/receipts are attached

☐ It is clear how we can reach you

☐ I have entered the bank details including the IBAN and the SWIFT/BIC numbers.

☐ I have signed the claim form

WHERE TO SEND YOUR PAPERWORK:

REFUNDS IN THE USA REGARDLESS OF YOUR NATIONALITY

Aetna Student Health
P.O. Box 14101, Lexington, KY 40512, USA
Tel +1 781 219 9100 (Business hours)
+1 800 783 7447 (Toll-free in the USA)
Fax +1 859 280 1269
E-mail: erika@aetna.com

AU PAIRS FROM SWEDEN, FINLAND, NORWAY AND DENMARK

Falck TravelCare
Box 44024, SE-100 73 Stockholm, Sweden
Tel +46 8 501 001 60 (24 hours)
+1 800 871 9211 (24 hours toll-free in the USA)
Fax +46 8 505 939 19
E-mail: erika@falcktravelcare.com

AU PAIRS FROM ALL OTHER COUNTRIES

AXA Assistance
c/o Inter Partner Assistance Service GmbH, Grosse Scharrnstr. 36, D-15230 Frankfurt/ Oder, Germany
Tel +49 89 500 70 137 (24 hours)
+1 800 847 3948 (24 hours toll-free in the USA)
Fax +49 89 500 70 394
E-mail: erika@axa-assistance.de