Kindly complete this form and return it ASAP to
AXA Assurances Luxembourg
1,place de l'Etoile L-1479 Luxembourg
T: (00352) 44 24 24-3003
claims@axa.lu

Insurance claim – Travel cancellation /

LUXAIR Airline

A complete report facilitates the processing of your claim!

Purpose of the claim :

☐ Travel cancellation

LUXAIR reservation no: ....

Contract n° : 27/0105912- TRAVEL PACKAGE

1. Policy holder

Surname...

Christian name: ....

Date of birth: ...... / ...... / ....

Address : ....

Private tel.: ....

Email : ....

Profession : ....

Office tel.: ....

2. Reimbursement by bank transfer

Bank: ....

IBAN account No: ....

BIC : ....

Account holder:

Signature of beneficiary: ....

☐ **Correspondence** : Please send all correspondence to the above mentioned Email address

3. Travel Information

Destination: ....

Date of reservation: / ...... / ....

Date of cancellation: / ...... / ....

Date of departure: ...... / ...... / ....

Date of return: ...... / ...... / ....

4. Amount claimed

Total travel costs: ....€

Cancellation fees: ....€

Amount to be reimbursed: ....€

Maximum 180€

Airport tax reimbursed by the airline?

☐ Yes ☐ Partially ☐ No

Amount: ....€

5. Reason for cancellation

In case of sickness, accident or death please complete below the name of the affected person

Full name: ....

Date of birth: ...... / ...... / ....

Address :..

....

Profession : ....

Office tel.: ....

Private tel: ....

Email

Please advise the reason for cancellation by completing the appropriate section below:

☐ **Disease:**
When was the illness noticed?
Date: ...... / ...... / ....
When did the patient first consult a physician (due to this disease):
Date: ...... / ...... / ....
Is the patient currently at home?
☐ Yes - ☐ No

Diagnosis:
....
....
....
....
....
....
....

☐ **Accident:**
Place: ....
Date: ...... / ...... / ....
Injuries:
....
....
....
Detailed description of the circumstances:
....
....
....
Is the patient currently at home?
☐ Yes - ☐ No

Is a third party liable: ☐ Yes - ☐ No
Full name:
....
Address :
....
....
....
Name and address of his /her insurance company:
....
....
....
His / her insurance policy no:
....

☐ **Loss (death):**
Date of Loss: ...... / ...... / ....
Date of funeral: .... / ...... / ....

☐ **Other reasons** (please give details):
....
....

6. Parties affected by the travel that has been cancelled, delayed or that required an early return

Full name	Relationship to the person whose illness, accident or death lead to the cancellation, delayed departure or early return
1)	....
2)	....
3)	....
4)	....
5)	....
6)	....

I hereby declare that all answers given in conjunction with this claim are true. Any intentional omission or misstatement could void AXA Assurances Luxembourg of its obligations..

Signed in .... , on ....

Signature of claimant
preceded by “read and approved”

Please submit the following documents with your claim:
- Confirmation of travel reservation
- Copy of the electronic tickets
- LUXAIR’s reimbursement letter

Kindly provide as soon as possible, in case of:
- Disease, accident or pregnancy:
  - a medical report (using the attached form)
- Loss: a death certificate
- Other reasons: official documents justifying the claim

MEDICAL REPORT/

To be completed by your GP

Please send in a sealed envelope to :

AXA Assurances Luxembourg
Demande annulation LUXAIR -
Secrétariat médical Sinistre Voyage
1 place de l'Etoile L- 1479 Luxembourg

LUXAIR reservation number: ....

Patient's full name: | Date of birth: ...... / ...... / ....
Address: | Date of exam: .... / ...... / ....

Reason: ☐ **Disease** ☐ **Accident** ☐ **Pregnancy**

1. Detailed description of diagnosis (nature of the disease and symptoms):
   ....
   ....
2. Date of first medical consultation: ...... / ...... / ....
3. Treatment : ....
   ....
4. Special exams? Please specify details and date(s). ....
5. Prescribed medication: ....
6. Duration and frequency of treatment and of medication: ....
7. Date of last medical consultation: ...... / ...... / .... Reason ....
8. Has the patient been affected for some time by this disease? ☐ yes ☐ no
   If yes, since when? ...... / ...... / .... Duration of treatment: ....
   - has their health worsened? ☐ yes ☐ no
9. Has the patient been advised not to undertake or not to continue the journey? ☐ yes ☐ no
   If yes, when? ...... / ...... / .... Why? ....
10. As a consequence, has there been an interruption of their current activities?
    ☐ yes ☐ no du ...... / ...... / .... au ...... / ...... / ....
11. Is the patient authorised to leave his home? ☐ yes ☐ no from ...... / ...... / .... until ...... / ...... / ....
12. Has the patient been or will be hospitalised? ☐ yes ☐ no from ...... / ...... / .... until ...... / ...... / ....
13. Medical history : ....
    Surgical history: ....
14. In case of a pregnancy, estimated date of birth? ...... / ...... / ....
15. Other comments: ....
    ....

Certified true and sincere,
Stamp and signature of physician

Signed in ...., on ...... / ...... / ....

The claimant has to assume all fees in relation with the medical consultation necessary to complete this form.