

Claim form

STS Student Travel School

- Au Pair Language School
 High School ILS
 IBS

Policy number	Destination	Start date	End date
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Personal Information – *Mandatory information*

First name		Last name		Date of birth Year/ Month/ Day/	
Address in home country		Zip code	City	Country	
E-mail address		Phone number in home country (incl. area code)		Phone number in host country (incl. area code)	
Name of host family or school		Address in host country		Zip code	City Country
Do you have any other insurance? <input type="checkbox"/> Yes <input type="checkbox"/> No		Name of insurance company		Type of insurance	Policy number
Name of bank		Account number	Account holders name	Iban code	Swift code

Illness or Accident

- Illness Accident Assault

Start date of illness or date of Accident Year/ Month/ Day/	Date of first visit to the doctor or hospital Year/ Month/ Day/	Diagnose	Have you had the same illness or conditions before? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, when?	
Have you been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No	From date	To date	Name of hospital	Name of doctor
Are you still on treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No	Expected future disability?			

Medical expenses (Attach original bills, receipts and reports with diagnosis)

Receipts nr	Treatment date	Type of cost and diagnose/symptom	Amount and currency	Who paid the bill?

Repatriation

- Illness or Accident Trip home due to emergency Other, please specify

When/where did the interruption of travel occur?	From date	To date	Number of days
Total price for your STS program?	Amount and currency		
Cost of any trip home/back	Amount and currency	Who paid for the trip home/back?	

Luggage Theft Loss Damaged Delay Other

Where did the damage or loss occur?	When did the damage or loss occur? Year/ Month/ Day/ Time/	Where were you when the damage or loss occurred?
Where was your property kept when the loss or damage occurred?	Was the room locked? <input type="checkbox"/> Yes <input type="checkbox"/> No Was the suitcase, cupboard etc. locked? <input type="checkbox"/> Yes <input type="checkbox"/> No	Where was the key kept?
Where did the baggage delay occur?	From date	To date

Luggage (Attach original receipts, warranties, photos and other documents that prove value and that you own the property).

Receipts nr	Detailed description of damaged or lost property	Purchase price and currency	Date of purchase	Current retail	Claim for compensation

Damage incident – *Mandatory information*

Describe how the damage/injury took place (add a separate paper, if needed).

Other compensation claim (Attach all documents in original).

Receipts nr	Date	Detailed description of cost	Amount and currency	Claim for compensation

Signature – *Mandatory information*

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

I hereby authorize doctors, related to my treatment, and other relevant authorization to supply Europ Assistance (or their appointed claims agent) with all the information required on my state of health for considering my claim.

I hereby authorize Europ Assistance (or their appointed claims agent, agent, etc) to claim from the National Social Insurance, on my behalf, for medical expenses in the EU/ESS and other countries.

I hereby authorize Europ Assistance (or their appointed agent or other relevant authorization) to release all of my personal health information in the event of an accident, illness or injury.

Date	Signature/ Guardians signature for minors	Print name
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Send the claim form to:

 Falck TravelCare AB (open from 8.30 am to 5.00 pm Central European time)
 Box 44024
 SE - 100 73 Stockholm
 Sweden

 Telephone: + 46 (0) 8 579 379 00 (Business hours)
 1 877 243 8735 (Toll free in the USA and Canada)

 Fax: + 46 (0) 8 505 939 19
 011 46 8 505 939 19 (Dialing from USA and Canada)

 E-mail: claims@falcktravelcare.com