Willis Towers Watson

CLAIMSFORM

Please fill in this form and its appendix A or B:

- Form A: insurance cover for travel cancellation and interruption, purchases' cover, luggage loss, late luggage delivery, extension of stay, delayed plane, missed flight and internet (late) delivery.

- Form B: Death and Invalidity Cover in case of a travel accident.

Please fill in the form, sign it and return it to us ASAP by email to the address wtw-lu.bcee@willistowerswatson.com or by post to the address: Willis Towers Watson Luxembourg, 145, rue du Kiem L-8030 Strassen.

☐ Miss ☐ Mrs ☐ Mr

Full Name : ____

Date of Birth : ____

Full Address : ____

Phone :______________________ **Mobile** : ____________________________________

E-mail : ____

IBAN Account Number : ____

Bank : ____

Matrimonial Status :

☐ Single ☐ Married ☐ Widow/er ☐ Divorced ☐ Other

Profession (optional) : ____

I, the undersigned, hereby certify that the above information is true.

Date : ______________________ **Signature** : ____________________________________

Data Privacy

The policyholder and/or the signing insured acknowledges that Willis Towers Watson Luxembourg collects the personal data provided via this claim form or subsequently through other means that are necessary to process and settle the claim in question. Willis Towers Watson Luxembourg will process your personal data in accordance with the Willis Towers Watson Luxembourg's privacy notice available upon request. The personal data collected through this claim form may be shared with third parties outside Willis Towers Watson where such third parties are involved in the processing and/or handling of the claim.

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CLAIMSFORM – FORM A

IN THE EVENT OF DAMAGE OR FINANCIAL LOSS

Type of card :

- ☐ Miles & More Luxair Visa
- ☐ Miles & More Luxair Visa Business
- ☐ Visa Premier
- ☐ Visa Classic
- ☐ Mastercard Blue
- ☐ Mastercard Blue Miles & More Luxair
- ☐ Mastercard Gold Miles & More Luxair
- ☐ Mastercard Gold
- ☐ Mastercard Business Miles & More Luxair

Card Number : ____

Nature of claim :

- ☐ Purchase Cover
- ☐ Travel Cancellation and Interruption
- ☐ Loss of Luggage
- ☐ Extension of stay
- ☐ Collision Damage Waiver
- ☐ Internet Delivery
- ☐ Late Luggage Delivery
- ☐ Delayed Plane
- ☐ Missed departure

Nature of trip :

- ☐ Private trip
- ☐ Trip for professional or commercial purposes

When did it happen ? ____

Where did it happen ? ____

Was the Police involved ?

- ☐ Yes
- ☐ No

If yes, what Police authority ? ____

Crime Reference Number : ____

Circumstances : ____

____

____

____

____

____

____

List of documents to be added to your Claim's Form (e.g. bills, place tickets, taxi receipts, etc…)	Date	Currency	Amount
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			
		Sub-total*	
Financial compensation from the carrier, airline company and other insurance companies		**Deduction**	

* Please make a subtotal for each currency. Please do not convert the amounts. State them in the original currency.

I, the undersigned, hereby certify that the above information is true.

Date : ______________________ **Signature** : _____________________________________

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CLAIMS FORM – FORM B

IN CASE OF INJURY DURING A TRIP RESULTING IN DISABILITY OR DEATH

Type of card :

☐ Miles & More Luxair Visa
☐ Miles & More Luxair Visa Business
☐ Visa Classic ☐ Visa Premier ☐ Visa Business
☐ Mastercard Blue Miles & More Luxair
☐ Mastercard Business Miles & More Luxair
☐ Mastercard Gold Miles & More Luxair
☐ Mastercard Blue ☐ Mastercard Gold ☐ Mastercard Business

Card Number : ____

Nature of the claim :

☐ Invalidity ☐ Death

Nature of trip :

☐ Private trip ☐ Trip for professional or commercial purposes

How long ago did you have the accident/illness?

When did it happen ? ____

Where did it happen ? ____

Was the Police involved ?

☐ Yes ☐ No

If yes, what Police authority ? ____

Crime Reference Number : ____

Description of the injuries or illness :

____

____

____

When were you given first aid ?

____

Name of the doctor who helped you : ____

Are you still undergoing any treatment ?

☐ Yes ☐ No

Name of your current GP : ____

Address :

____

Did you see a Specialist ?

☐ Yes ☐ No

If yes, when ? _____________________________ Who ? _______________________________

Did you suffer from these ailments before the injury or illness ?

☐ Yes ☐ No

If yes, when did these ailments first ever appear : ________________________________

I, the undersigned, hereby certify that the above information is true.

Date : ____________________ **Signature** : ___________________________________