



## 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.spuerkeess@willistowerswatson.com](mailto:wtw-lu.spuerkeess@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 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. The insured may have to submit medical data to substantiate his/her claim.

Willis Towers Watson Luxembourg will process the insured's personal data in accordance with the Willis Towers Watson Luxembourg's privacy notice which includes information on how to exercise individual rights: <https://www.wtwco.com/fr-LU/Notices/politique-de-confidentialite-insurance-brokerage>.

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 as described below and in our privacy notice.

The following data: insured's first name and last name; address; nationality; date of birth will be processed for the purpose of verifying the insured's identity, carry out due diligence in accordance with Sanctions and Anti Money Laundering Legislation by WTW Global Delivery and Solutions India Private Limited ("WTW Mumbai"), a company of the WTW group located in Mumbai (India). WTW Mumbai exchanges information for the due diligence purpose mentioned above with Regulatory DataCorp Limited, a global data provider company based in the United Kingdom and Wales with its head office at 6 Lloyd's avenue, London, EC3N 3AX. Willis Towers Watson Luxembourg shall remain responsible for the confidentiality of this data.



The insured expressly allows Willis Towers Watson Luxembourg to store his/her data including personal data, such as: name/surname, address, date of birth, nationality, profession, information related to the insurance contract in the broking management tool provided by our IT service provider located in Belgium. This data will not be processed by this IT service provider except where necessary to provide the maintenance services of the broking management tool.

If you have any questions, please contact [RGPD@willistowerswatson.com](mailto:RGPD@willistowerswatson.com).

The insured agrees to the sending of the data listed above by Willis Towers Watson Luxembourg to WTW Mumbai and from WTW Mumbai to Regulatory DataCorp Limited in order for WTW Luxembourg to comply with the requirements of the AMLCTF law, and the hosting of its personal data by our IT service provider located in Belgium. By signing this form, the insured expressly consents to the processing of his/her medical data as described in this form and in the Willis Towers Watson Luxembourg Privacy Notice.



**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

**Card Number:** \_\_\_\_\_

**Nature of claim:**

- |   |  |
|---|--|
| <input type="checkbox"/> Purchase Cover                       | <input type="checkbox"/> Internet Delivery     |
| <input type="checkbox"/> Travel Cancellation and Interruption | <input type="checkbox"/> Late Luggage Delivery |
| <input type="checkbox"/> Loss of Luggage                      | <input type="checkbox"/> Delayed Plane         |
| <input type="checkbox"/> Extension of stay                    | <input type="checkbox"/> Missed departure      |
| <input type="checkbox"/> Collision damage waiver              |  |

**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?** \_\_\_\_\_

**Police 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)			
		<b>Sub-total*</b>	
<i>Financial compensation from the carrier, airline company and other insurance companies</i>		<b>Deduction</b>	

\* 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:** \_\_\_\_\_



**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

**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? \_\_\_\_\_

Police 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:** \_\_\_\_\_