



**TOKIO MARINE**  
KILN

# CLAIM FORM

## Swimrun-Athletes-Insurance Program

**In case of any medical emergency, please directly contact the 24-hour emergency hotline (MOS medical helpline) +49 (0)69/ 9 77 88 99-999**

**In case of any other claims request, please contact the hotline of our claims handling office INTRUST via +49 (0) 2058 / 9230 51 or send an email to [swimrun@cl-int.com](mailto:swimrun@cl-int.com)**

### **STEP 1 – CLAIM FORM COMPLETION REQUIREMENTS**

- Please use block letters.
- Please read this claim form carefully and complete ALL required steps outlined on this form.
- Please retain a copy of ALL documents for your records.
- Documents in a foreign language are required to be translated into English at your own expense.
- The claim form and ALL supporting documentation may be posted or e-mailed to us.
- Please provide us with the original receipts, reports or any other documentation to be submitted by post in order to substantiate the claim.
- Please refer to the specified documentation requirements that you will need to provide when lodging your claim. As each is unique, further information may be requested by us.
- A copy of your certificate of insurance as well as a confirmation of race participation must be supplied with your claim.
- If any part of your claim is of a dishonest or fraudulent nature, your claim will be denied and referred to the relevant authorities.
- This claim form should be completed and returned with supporting documentation to [swimrun@cl-int.com](mailto:swimrun@cl-int.com) or to the following address:

#### **inTrust Germany**

**Cunningham Lindsey Zorn GmbH, Wilhelmstraße 96, 42489 Wulfen**

**[www.intrust-tpa.com](http://www.intrust-tpa.com)**



**STEP 2 – CLAIMANT DETAILS**

- 1. Name of insured person: \_\_\_\_\_
- 2. Date of birth: \_\_\_\_\_
- 3. Address: \_\_\_\_\_
- 4. Contact details (phone, email): \_\_\_\_\_
- 5. Registration No.: \_\_\_\_\_

6. Have you made previous accident, liability or travel insurance claims? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please complete the table below:

Date of Claim	Name of Insurer	Claim Number	Details of Claim	Amount Paid

7. Is this claim covered by any other insurance policy (i. e. through your employer, credit card provider, associations etc.)? YES \_\_\_\_\_ NO \_\_\_\_\_

If yes, please advise below:

Name of Insurer	Type of insurance (accident, liability or travel insurance)	Policy no.	Claim no.	Contact/ phone no.

**STEP 3 – CLAIM INFORMATION**

In this section we will ask for the circumstances of your claim and the amount that you are claiming.

General Claim Information:

1. Date of loss: \_\_\_\_\_ 2. Location and country of loss: \_\_\_\_\_

3. Circumstances of loss (Please provide a detailed description of what happened and where. Use an additional sheet, if necessary.)

\_\_\_\_\_

\_\_\_\_\_

4. Estimated total amount of costs: \_\_\_\_\_

5. Please choose the applicable box(es) below relating to your claim and answer the corresponding Section.

- \_\_\_ **A. Personal Accident Insurance**
- \_\_\_ **B. Personal Liability Insurance (subsidiarily applicable only)**
- \_\_\_ **C. Travel and Curtailment Insurance**



**STEP 3 – A. Personal Accident Insurance**

1. What were the consequences of the accident? (diagnosis / type and extent of the injuries)
2. \_\_\_\_\_  
\_\_\_\_\_
3. Did you consume alcohol/ drugs/ medication within the last 24 hours prior to the accident?  
NO \_\_\_\_ YES \_\_\_\_ (Please state what type, the amount and within which time period)  
\_\_\_\_\_
4. When did the medical treatment/care start? (date/time): \_\_\_\_\_
5. Please give name and address of the medical attendant (doctor/hospital):  
\_\_\_\_\_
6. Please submit any medical report available. In case you have been treated in a hospital, please submit the hospital report.
7. Did you suffer from any illness or other health issues before this accident? (i.e. epilepsy, Parkinson, fainting, cramping, dizziness, stroke, hypertonia, diabetes, nerve damage, vision or audio limitations)  
YES (What?) \_\_\_\_\_ NO \_\_\_\_\_
8. Have you had accidents before, which led to an injury?  
YES (When? Which type of injury?) \_\_\_\_\_ NO \_\_\_\_\_

**STEP 3 – B. Personal Liability Insurance**

If anyone is holding you responsible for their claim, insist their claim must be in writing. **Do not admit liability.**

Are there witnesses of the incident or did the Police record the incident?

- NO \_\_\_\_ YES \_\_\_\_ Name(s) and address(es) of witness(es) \_\_\_\_\_  
 \_\_\_\_\_  
 Police record / journal no. \_\_\_\_\_  
 Address of Police Station \_\_\_\_\_

Please give us the following details about the Third Party involved:

1. Name of third party: \_\_\_\_\_
2. Date of birth / age: \_\_\_\_\_
3. Address: \_\_\_\_\_
4. Contact details (phone, email): \_\_\_\_\_

**STEP 3 – C. Travel and Curtailment Insurance**

1. Please provide us with the following documents / information:
  - Attach -> your travel itinerary and cancellation documents (available from your travel agent)
  - > your receipt from the travel provider showing the full cost of the travel tickets or minimum prepaid travel expenses
  - > a list of total costs claimed
  - > documentation and confirmation/receipt of paid entry/participation fee
  - > any medical documentation in case of any medical reason (i.e. serious accident/unexpected serious illness or pregnancy etc.)



2. On what date did you amend/cancel the trip? \_\_\_\_\_

3. Reason(s) for trip amendment /cancellation \_\_\_\_\_

**STEP 4 – PAYMENT DETAILS**

To whom should any payment be made? \_\_\_\_\_

For Electronic Fund Transfer, please provide your full bank details; Bank Name, Bank Address, Account No, Sort Code, Swift Code & IBAN and Name of Account Holder:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PERSONAL OR SENSITIVE INFORMATION – ACCESS TO MEDICAL REPORTS  
(a signed authorisation must be completed by the sick/injured person)**

As part of your claim a medical report and/or medical notes may be required from your doctor. However, before we can apply for a medical report / notes your consent is needed. Before signing the consent to obtain medical information at the end of this form, you should know that you have the following rights:

- 1. You can withhold your consent, but if you should do so we may be unable to process your claim.
- 2. If you wish to see the report we will tell you at the same time that we write to the doctor and you will then have 21 days to contact the doctor about arrangements for you to see the report /notes. Whether or not you wish to see the report / notes before they are sent to us, the doctor must let you see a copy for up to six (6) months after it is supplied to us, if you ask for it.
- 3. You can ask your doctor to amend any part of the report / notes, which you consider wrong or misleading. If the doctor will not agree to this, you may add your own comments.
- 4. Your doctor can, in certain circumstances, withhold from you the report / notes or any part of it.

**Consent to Obtain Medical Report / Medical Notes**

I have read the statutory rights above, under the Access to Medical Reports Act 1988 and I hereby agree to Tokio Marine Kiln Group Ltd as well as inTrust Germany on behalf of Tokio Marine Kiln Group Ltd seeking medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health in connection with this claim.

\_\_\_\_ I wish to see the report / notes before they are sent to Tokio Marine Kiln Group Ltd or inTrust Germany on behalf of Tokio Marine Kiln Group Ltd (tick as required)

Full Name of Insured or Authorised Person: \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

\* If insured person is a minor, please provide signature of parent or legal guardian

**Declarations**

I declare that to the best of my knowledge, the particulars presented herein are true. I understand that any person who knowingly and with intent to defraud or deceive any insurance company, files a claim containing any materially false, incomplete or misleading information, may be subject to prosecution for insurance fraud. I also understand and consent that information herein may be made available to other insurers for underwriting and claims handling purposes and consent to Tokio Marine Kiln Ltd as well as inTrust Germany on behalf of Tokio Marine Kiln Group Ltd seeking information from other insurers to confirm any information presented.

Full Name of Insured or Authorised Person: \_\_\_\_\_

Date \_\_\_\_\_ Signature \_\_\_\_\_

\* If insured person is a minor, please provide signature of parent or legal guardian



**MEDICAL CERTIFICATE**

**regarding illness/ accident/ unexpected vaccination intolerance or prophylaxis intolerance of the insured or risk person – to be completed and signed by the attending physician**

Patient’s name \_\_\_\_\_ date of birth \_\_\_\_\_

Patient’s address \_\_\_\_\_

**1. Diagnose(s)**

Diagnose(s) including ICD-Code, which led to the trip cancellation

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of first notice of this diagnose(s) respectively date of accident \_\_\_\_\_

When did the patient first see a doctor about his / her symptoms? (date) \_\_\_\_\_

**1.1 Pregnancy**

When was the pregnancy ascertained and in which week of the pregnancy? \_\_\_\_\_

When was it first apparent that the journey / event could not be reasonable undertaken in view of the pregnancy? (date) \_\_\_\_\_

Have there been any complications? NO \_\_\_\_ YES \_\_\_\_ Which? \_\_\_\_\_

Has there been any inpatient treatment or is it scheduled or recommended? NO \_\_\_\_ YES \_\_\_\_  
When? \_\_\_\_\_

**2. Incapacity for work**

Has there been any incapacity for work due to the illness/accident?

YES \_\_\_\_ from \_\_\_\_\_ until \_\_\_\_\_

NO \_\_\_\_ reason(s), why not: \_\_\_\_\_

**3. Inpatient Treatment**

Has there been inpatient treatment ? NO \_\_\_\_ YES \_\_\_\_ from \_\_\_\_\_ until \_\_\_\_\_

**If YES, please provide us with a medical report from the treating hospital attached to this Medical Certificate! Thank you!**

**4. Therapeutic measures and medications**

Which therapeutic measures have been taken and what was the medication? \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

What are the treatment dates related to this illness? (Please give single dates.) \_\_\_\_\_

Has the patient been referred to a specialist? NO \_\_\_\_ YES \_\_\_\_ on (date) \_\_\_\_\_

Please state name and address of the specialist \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_



**5. Progress of illness / medical history**

Did the illness occur a longer time ago? NO \_\_\_ YES \_\_\_ since (date) \_\_\_\_\_

Have there been or are there illnesses, which are or might be associated with the current diagnose(s)?

NO \_\_\_ YES \_\_\_ since \_\_\_\_\_ diagnose \_\_\_\_\_ ICD Code \_\_\_\_\_

What are the treatment dates to this (pre-)existing illness within the last two years? (dates) \_\_\_\_\_

When did the (pre-)existing illness worsen? Since (date) \_\_\_\_\_

**6. Travel Reservations**

Have you been asked whether the patient is fit to travel prior to the travel booking?

NO \_\_\_ YES \_\_\_ first on (date) \_\_\_\_\_

Has the patient been fit to travel at the time of booking? NO \_\_\_ LIMITED \_\_\_ YES \_\_\_\_\_

When was it obvious that -from a doctor's perspective- due to health reasons the booked journey / event was no longer possible? (date) \_\_\_\_\_

When did you as the attending physician advise the patient against the journey? (date) \_\_\_\_\_

In case, the date when you advised against the journey, would be different to the date of first notice of the current diagnose(s), please advise us of the reasons why: \_\_\_\_\_

\_\_\_\_\_  
**Place / date and signature of attending physician**

\_\_\_\_\_  
**Practice stamp of attending physician**