

Policy Details

Policyholder	Lipno Lake s.r.o.		
IČ	26100452	Policy No.	2209272618

Insured Details

Name and Surname			
Contact Address			
E-mail	@		
Date of Birth		Mobile Phone	+420

Trip Details

Deposit paid		Total Amount paid		Trip Dates	From:	to:
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Claim Details

Trip Cancellation	<input type="checkbox"/>	Trip Interruption	<input type="checkbox"/>
Date of Loss		Time of Loss	
Place of Loss			

Accompanying Persons:

Name and Surname	Date of Birth	Relationship to Insured

Description of the claim:

Was the claim inspected?	<input type="checkbox"/> yes <input type="checkbox"/> no	By whom	
Address, phone and e-mail			

Claims Witnesses

Name and surname	Phone	E-mail

Total amount of the cancellation fees	
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Total Claimed Amount (in original currency)

My bank account number

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Declaration:

I declare that I have answered all my questions truthfully and completely and that I am aware of the consequences of incorrect responses to the insurer obligation to indemnify.

I agree that Colonnade Insurance SA, the Colonnade, in accordance with Act No. 89/2012 Coll., By the Civil Code, by itself or through an authorized physician, will obtain my health status, including any medical records, from any of my doctors I have been treated, treated or will be treated, a health insurance company, any public authority or other insurer with whom I have contracted accident insurance. And I also empower Colonnade to get information from those people or organs about my health status, look into my medical records and other records of my health, get statements or copies of them. I grant this consent and empowerment for the purpose of investigating claims even after my death.

For the purposes of this authorization and in so far as it exempts those persons and bodies from their legal or contractual obligations of confidentiality, even under Act No. 372/2011 Coll., On Health Services. I further declare that the persons whose personal data I have provided to Colonnade will become aware of the Colonnade Privacy Policy no later than 1 month from the date of such disclosure.

I have another travel insurance/ trip cancellation policy:

yes no

Insurance
Company

Policy No.

Personal Data Protection

For further information on the processing of your personal information, including any rights you may claim in this regard, please refer to the Colonnade website under the following link: <https://www.colonnade.cz/ochrana-osobnich-udaju>.

Insured Signature

Date of sending:

Policyholder Signature

Stamp:

Please send the completed form together with requested documents to

Colonnade Insurance S.A., organizační složka - oddělení likvidace škod,
Na Pankráci 1683/127, 140 00 Praha 4 or via e-mail: skody@colonnade.cz

Enclosures:

<input type="checkbox"/> Medical report stating the reason of trip cancellation/interruption
<input type="checkbox"/> Certificate of incapacity to work or death certificate of the person for whom the trip was canceled
<input type="checkbox"/> Police report stating the reason of trip cancellation/interruption
<input type="checkbox"/> A copy of the notice of employment confirmed by the employer's HR department
<input type="checkbox"/> Trip booking confirmation
<input type="checkbox"/> Invoice or other document stating the amount of cancellation fees
<input type="checkbox"/> Other