COLONNADE
A FAIRFAX COMPANY

DAMAGE NOTIFICATION FORM
REGARDING PAYMENT CARD TRAVEL INSURANCE

Payment card information:

Name of the bank:		Insurance contract number: *(on the assistance card)*	
Type of payment card:		Payment card number:	

The insured:

Name, surname, title					
Contact address					
Date of birth		Telephone:		E-mail	
Is the insured the holder of the card specified above?	o yes o no	If not, give the name of the holder and his/her relation to the holder			

Type of damage:

o medical expenses & assistance service	o delayed flight	O accident (permanent consequences, death)
o loss and damage of baggage and personal belongings	o legal aid and bail	o liability for damage
o delayed luggage	o trip cancellation	o hijacking
o other________________________________		

Commencement of trip:		End of trip:		Business trip	o yes o no
Date of damage occurence:		Time:		Place:	
Amount of claim (in original currency)					

Description of circumstances of the occurrence of damage:

Were the circumstances investigated?	❑ yes ❑ no	Authority	
Address			

Witnesses:

Surname, name		Address	
Surname, name		Address	

Colonnade Insurance S.A., branch office

Please, pay the settlement to account no./bank code	

I am insured with another insurer:

❑ NO ❑ YES (name of the insurance company) :

Representations:

The insured represents that all the information stated herein is true and complete and that he/she is aware of the consequences of incorrect answers in respect to the obligation of the insurance company to settle the claim.

The insured hereby agrees that the insurer may ascertain and check his/her physical and psychological health and the health of the other insured with all physicians, medical facilities and facilities providing health care, where he/she has been, is being or will be treated. The policy holder grants this consent for the purpose of claims settlement, even for the time after his/her death and authorises the physicians, medical facilities and facilities providing healthcare to prepare medical reports, extracts from medical documentation and to lend such documentation to the insurer. The policy holder hereby releases the physicians, medical facilities and facilities providing healthcare from confidentiality.

Under Act no. 101/2000 Sb. on the Protection of Personal Data, the insured hereby grants Colonnade Insurance S.A., branch office, ID 04485297, Na Pankráci 1683/127, 140 00 Prague 4 (hereainfter "the controller") his/her consent to personal data processing, including sensitive personal data:

- in the extent necessary for the fulfilment of the rights and obligations arising from the insurance contract, i.e. in which the insured provides them to the controller when reporting the insured event or during further procedure regarding the insured event (via the form of "Notification of Claim" and in which the controller obtains them from the medical facilities under seciton 2828 Act no. 89/2012 Sb., Civil Code;
- for the purpose of the settlement of the claim and mutual rights and obligations arising from the insurance contract;
- for the time necessary for the exercise of all rights and the performance of all obligations arising from the insurance contract.

By providing Colonnade with your personal data in connection with the insured event, you understand that your Personal Data will be collected and processed in accordance with Act no. 101/2000 Sb., on Personal Data Protection and with the Rules for Personal Data Protection available at www.colonnade.cz.

Personal data thus provided will be processed by the controller or through an authorised processor. However, in all cases all duties arising for the controller and the processors under Act no. 101/2000 Sb. will be observed and the insured will be protected against any unauthorised interference with his/her private and personal life.

Providing the personal data is voluntary, however as far as sensitive personal data are concerned, providing the consent is necessary for a due investigation of the claim and, based on the results of the investigation, for the payment of the claim.

The insured has the following rights:

- to be provided with information regarding his/her personal data that are processed,
- to ask the insurer to correct his/her personal data should he/she find that they are incorrect,
- to request an explanation from the insurer or to request that the insurer eliminates a defect, if the insured finds or believes that the controller processes his/her personal data in conflict with the protection of the private and personal life of the insured or in conflict with the laws and regulations,
- to file an application with the Office for Personal Data Protection to remedy the situation if the controller breaches its obligations.

Signature of the insured		Posting date:	

Send the completed form and other required documents
to the following address, please:

Colonnade Insurance S.A., organizační složka
oddělení likvidace škod
Na Pankráci 1683/127
140 00 Praha 4

e-mail: skody@colonnade.cz
Tel: +420 234 108 311
Fax +420 234 108 387
www.colonnade.cz