



DAN EUROPE ACCIDENT CLAIM FORM

To ensure that a claim is dealt with and evaluated promptly please send the following documents as soon as possible:

- The present DAN Europe Accident Form filled out by the insured member
 Copy of medical report/s detailing the diagnosis
 Copy of payments receipts/estimated costs

- > For requests of direct payment to the hospital for the medical costs, documents need to be emailed to:

> For reimbursement requests documents need to be email	iled to: claims@idassure.eu	
INSURED MEMBER DETAILS		
NAME	SURNAME	INSURANCE NUMBER
PHONE CONTACT	EMAIL CONTACT	DATE OF BIRTH
ACCIDENT OCCOURED WHILE		
SCUBA DIVING FINSWIM	MING UNDERWA	ATER PHOTOGRAPHY OTHER
FREE DIVING UNDERWA	ATER ORIENTEERING SNORKELI	LING
UNDERWATER RUGBY SPEARFIS	HING DRY TRAIN	NING
ACCIDENT DETAILS		
DATE OF ACCIDENT		APPROX HOUR OF ACCIDENT
PLACE OF ACCIDENT (SITE)		COUNTRY OF ACCIDENT
SHORTLY DESCRIBE THE EVENTS TH	HAT LED TO THE ACCIDENT:	





COMPLETE THIS SECTION **ONLY** FOR SCUBA DIVING ACCIDENTS

APPROXIMATE TOTAL NUMBER OF DIVES DONE TOT NUMBER OF DIVES DONE TOT NUMBER OF DIVES DONE TOT NUMBER OF DIVES DONE ON THE ACCIDENT DATE DIVE COMPUTER USED ELECTRONIC DIVE LOG AVAILABLE ENTRY TIME SURFACE INTERVAL Specific comments ENTRY TIME SURFACE INTERVAL ENTRY TIME SURFACE INTERVAL SPECIFIC comments ENTRY TIME SURFACE INTERVAL FOR DIVE DAYS SURFACE INTERVAL ENTRY TIME SURFACE INTERVAL FOR DIVE DAYS SURFACE INTERVAL ENTRY TIME SURFACE INTERVAL FOR DIVE DAYS SURFACE INTERVAL ENTRY TIME SURFACE INTERVAL FOR DIVE DAYS SURFACE INTERVAL FOR DAYS SURFACE INTERVAL FOR DAYS SURFACE INTERVAL FOR DAYS SURF	CERTIFICATION LEVEL	(TOT NUMBER OF DIVES DONE IN THOSE CONSECUTIVE DAYS					
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TOT TIME AT MAXIMUM DEPTH	Specific comments	DEPTH	TIME		RAPID ASCENT		YES		NO	





HOSPITAL - CLINIC - DOCTOR (DETAILS)

NAME OF FIRST MEDICAL STRUCTURE OR DOCTOR

EMAIL CONTACT	PHONE CONTACT
NAME OF SECOND MEDICAL STRUCTURE OR DR (IF ANY)	
EMAIL CONTACT	PHONE CONTACT
ESTIMATED COSTS - OR – PAID RECEIPT	
ADDITIONAL MEDICAL PRIVATE INSURANCE (IF ANY)	
INSURANCE NAME	POLICY NUMBER
PHONE CONTACT	EMAIL CONTACT
CLAIM NUMBER REFERENCE (IF SAME ACCIDENT WAS NOTIFIED TO ADDITIONAL INSURANCE)	
l declare that to the best of my knowledge and belief the statements made on this form ar	e true and complete.
Signature	Date

Important Data Protection Notice

The Insurer and its affiliates process personal data in accordance with the provisions of the applicable Data Protection legislation and accordingly accept your authorization to process such data for the following purposes or for any other purpose not incompatible or inconsistent with this legislation:

- i. Updating records (manual or electronic) of the Insurer and/or its affiliates;
- ii. Administering your insurance policy, underwriting, handling and settling of claims, detecting, preventing and suppressing of fraud and keeping statistics on an anonymous basis;
- iii. Transferring data between the Insurer and its affiliates, including VING Insurance Brokers Ltd and Divers Alert Network (DAN) Europe;
- iv. Obtaining medical information about you and accordingly accepts your authorization for any doctor, hospital, laboratory or other insurance provider to disclose full information about you to the Insurer and/or any of its affiliates;
- v. Informing you, without being obliged to do so, of any new services provided by us or any changes in the law, policy or practice which may be of interest to you by email, fax or other electronic means.

You also declare that you understand that you have the right to request access to your personal data. Please contact IDA Ltd – Claims Department in writing for any further information.