



CLAIM FORM FOR MEDICAL EXPENSES AND OTHER EXPENSES

(to be completed by the person who purchased the insurance)

SECTION 1 – YOUR DETAILS

Mr / Mrs / Miss Forename: _____ Surname: _____

Address: _____

_____ Postcode: _____

Daytime telephone number: _____

Occupation: _____ Date of Birth: _____

SECTION 2 – DETAILS OF YOUR TRIP

Date holiday was booked: _____ Destination: _____

Date Deposit was paid for holiday: _____ How much paid?: £ _____

Date final balance was paid: _____ How much paid? £ _____

Date Insurance purchased: _____ How much paid? £ _____

Certificate/Policy Number: _____

Scheduled date of departure: _____ Schedule date of return: _____

If you did not return on the scheduled date, what date did your return: _____

SECTION 3 – DETAILS OF ILL/INJURED PERSON

Name of Ill/Injured Person: _____ Date of Birth: _____

Details of Illness/Injury suffered: _____

Date Illness/Injury commenced: _____

Was the 24 hour emergency service contacted? YES/NO

If YES please confirm by whom: _____ and

Date of initial contact: _____



If the injury was the result of an accident please give full details including dates and the names of any other parties involved with their Insurance details if known.

Date and time of admission to hospital: _____

Date and time of discharge: _____

Name and address of Hospital _____

Did you return from your holiday earlier than planned? YES/NO

If YES on what date _____

Are you claiming for any unused accommodation or travel? YES/NO

If YES please give details _____

SECTION 3 – EXPENSES INCURRED

Date expense incurred	Name and address of service provider	Was an EHIC presented?	Amount of expense (please state clearly the currency)	Paid by you?	For office use only

DISCLAIMER – The following should be completed and signed by those who incurred the medical expenses on an EC Country.

I hereby consent to Underwriters seeking reimbursement of medical expenses paid by them out of medical treatment received in _____(country) from an illness/injury which commenced on _____ (date).

Signed _____

Date: _____



SECTION 4 – PRIVATE HEALTH INSURANCE

Do you have Private Health Insurance? YES/NO

If YES please provide:

Name of Insurance Company: _____

Address: _____

Policy Number: _____

=====

DECLARATION

I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form and information provided by myself on pages attached to this form is, to the best of my knowledge and belief, true in every respect and that the amounts claimed have not been refunded to me or claimed from any other source.

YOU MUST READ THE DECLARATION BEFORE SIGNING.
PLEASE READ AND SIGN THE ACCESS TO MEDICAL RECORDS CONSENT FORM
OVERLEAF

Signed: _____ Date: _____

Please use additional paper if space provided on this form is insufficient, please attach additional paper when submitting this form.

Number of additional pages attached: _____

Your Insurers' preferred method of settlement is by BACS transfer and if this is convenient to you please complete the following. Alternatively, if preferred payment by cheque can be arranged.

Account name: Account number:

Bank name: Sort Code:

GUIDANCE NOTES

Please note that if you are unable to supply any of the evidence we request, you should include a separate covering note explaining this. This will enable us to deal with your claim promptly.

In all cases original documents must be provided. We are unable to accept photocopies (unless stated).



DOCTOR'S REPORT

The claimant must at his or her own expense have the following certificate completed by a duly qualified medical practitioner.

Name of Claimant _____

Name of Patient (if different from Claimant) _____

Patient's Date of Birth _____

Relationship to Claimant _____

Dear Doctor

The above named person has submitted a claim under their Travel Insurance Policy. In order for us to assess the claim we would be grateful if you would answer the questions below.

Name of person to whom this report refers (the patient) _____

Are you the patient's usual practitioner? YES/NO

How long have you acted in this capacity? _____ Years

What is the precise nature of the condition, illness or injury that has caused a claim to be made under this Policy?

When were you first consulted about this condition? _____

Has the patient suffered from the same or a similar condition in the past? YES/NO

If so please advise details and dates of all previous treatments _____

Has the patient been included on a waiting list for in-patient treatment for this condition? YES/NO

If so please advise the date they were put on the list _____

Did the patient consult you for permission to travel? YES/NO

If YES please give date: _____

If so, did you consider the patient fit to travel at the time? YES/NO

If claim was due to pregnancy please give: Date of confinement: _____

Date pregnancy confirmed: _____

DECLARATION

I have examined the patient and/or his medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signed _____ Practice Stamp: (Please include address & telephone number if not on stamp)

Name _____

Qualification _____