

# Notification Claim Form

Claim Notification Reference:

\_\_\_\_\_

(For Office Use Only)

Your Details:

Name:

Type of Claim:

Date:

Address:

Contact Number:

Email Address:

## Important information / What next?

1. Please complete the attached claim form
2. Any additional notes/comments please attach to the back of this form
3. Please list supporting documentation that will be attached to this claim form:

a) \_\_\_\_\_

b) \_\_\_\_\_

c) \_\_\_\_\_

d) \_\_\_\_\_

e) \_\_\_\_\_

f) \_\_\_\_\_



# Notification Claim Form

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Travel Details:

Date booking the trip:

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Departure Date:

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Return Date:

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Country:

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Purpose of trip:

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What are you claiming for:

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Amount: £

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# Medical Expenses and Curtailment Claim Form

Please TICK

Illness

Injury

1. Date and time illness/ injury occurred:

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2. Country where illness or Injury occurred:

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3. Full description/ diagnosis of illness or injury:

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4. Previous Medical History

Have you suffered from the condition that has resulted in the submission of this claim, or any related condition prior to purchasing insurance or booking your holiday or prior to travelling?

Yes  No

If **YES**, please have your doctor complete the attached medical certificate

5. Hospital/ clinic details when treatment was provided:

Name:

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Address:

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Telephone No: (if known)

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Name of treating doctor: (if known)

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# Medical Expenses and Curtailment Claim Form

6. If you were an inpatient please complete the following:

a) Date of admission: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

b) Date of Discharge: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

c) Did you contact the Medical Assistance Company as stated on your policy: Yes  No

If your answer is **NO**, please provide a written explanation as to why the medical assistance company was not contacted:

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If Yes, please confirm the date of your first call: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

Person spoken to and reference number:

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d) Did you take your EHIC Yes  No

Was it presented to the doctor/hospital: Yes  No

e) Do you hold any private medical insurance e.g. BUPA, PPP etc? Yes  No

If Yes, please confirm the provider, policy number and address of the insurer:

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# Medical Expenses and Curtailment Claim Form

Please list Medical Expenses claimed:

| Please list expenses being claimed and treatment received | Currency paid and amount paid | Receipt attached                                   | State to whom payment should be made |
|---|-------------------------------|--|--------------------------------------|
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |

**Curtailment- Please complete this section if you returned to your home address earlier than scheduled ONLY**

Reason for curtailment:

Illness       Injury       Illness/ injury or death of relative       Other

Reason for curtailment:

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If curtailment is due to illness/ injury or death of someone not on your policy please confirm your relationship to them:

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# Medical Expenses and Curtailment Claim Form

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Date on which you returned:

Yes  No

Number of complete days unused:

\_\_\_\_\_

Were you accompanied?

Yes  No

If Yes, by whom:

\_\_\_\_\_

Did you contact the Emergency Company as stated on your policy:

Yes  No

If your answer is **NO**, please provide an explanation as to why the Emergency assistance company was not contacted:

\_\_\_\_\_

\_\_\_\_\_

If **YES**, please confirm the date of your first call:

\_\_\_\_\_

Person spoken to and reference number:

\_\_\_\_\_

Was the airline/train company/ ferry etc contacted to re-arrange travel dates:

Yes  No

# Medical Expenses and Curtailment Claim Form

Please complete the table below and list any additional expenses incurred in returning home:

| Please list expenses being claimed and treatment received | Currency paid and amount paid | Receipt attached                                   | State to whom payment should be made |
|---|-------------------------------|--|--------------------------------------|
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |
|   |                               | Yes <input type="radio"/> No <input type="radio"/> |                                      |

Do you hold any form of bank account/ credit card that offers you complimentary travel insurance that cover the circumstances surrounding your claim?

Yes  No

If **YES**, please confirm the following:

Card number:

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Issuing Bank:

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Card Type (Gold, Platinum, Standard):

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Has a claim to a third party been submitted?

Yes  No

If **YES**, please provide details:

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Is there any other relevant policy that may cover the circumstances surrounding your claim? Other policies, Barclaycard, Amex

Yes  No

# Medical Expenses and Curtailment Claim Form

If **YES**, please provide details:

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If the claim is in relation to injury please confirm the following:

1. An outline of the circumstances giving rise to the accident

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2. If a third party was involved the name and address of the Third Party and their insurance details if known

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3. In the event that you are pursuing a claim for damages against a Third Party please provide the name and address of any solicitor who may have been appointed and there reference number

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4. If no Third Party was involved please clarify who or what was at fault and why

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# Medical Expenses and Curtailment Claim Form

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If your claim is agreed how would you like to be paid (please tick ONE  ONLY):

Cheque:

Confirm payee name: \_\_\_\_\_

Or direct to your bank account (UK bank accounts only):

Bank Name: \_\_\_\_\_

Branch: \_\_\_\_\_

Bank Sort Code: \_\_\_\_\_

Account Number: \_\_\_\_\_

Account Holder: \_\_\_\_\_

Type of Account (Current, Gold, Platinum etc): \_\_\_\_\_

## DECLARATION

**IMPORTANT- Failure to sign will result in your claim form being returned.**

I/we declare that the above statements are true and correct to the best of my/out knowledge and belief. I/we have not withheld any information within my/our knowledge connected with this claim. I/we agree to provide the insurer with any further information as may be reasonably required. I/we understand that the insurer does not admit liability by issue of this form. **WARNING – the making of a fraudulent or knowingly exaggerated claim is a criminal offence. We investigate all cases and any person suspected of fraud is reported to the police with whom we always co-operate.**

## DATA PROTECTION ACT

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and may be shared with other organisations for this purpose. I/we understand that you may ask for information from other organisations to check the answers I/we have provided.

## IMPORTANT

In the event of a third party being liable, all rights in this matter are subrogated to the travel insurance underwriters or their agents on all settlements of this claim.

Signature: \_\_\_\_\_

Date: \_\_\_/\_\_\_/\_\_\_