Policy Number: ______________________

Personal Details of all people claiming

Title	Full Name	Date of Birth	Occupation	Usual Country of Domicile

Contact Details

Claimant Address: ______________________

____

____

Postcode: ______________________

Daytime Telephone: ______________________

Email Address: ______________________

Wherever possible we will try and communicate with you by Email or telephone for a quicker service.

Travel Details

Travel Destination: Country: ______________________

Resort: ______________________

Date of booking: ______________________

Departure date: ______________________

Return date: ______________________

Purpose of Trip: Business Pleasure Other

____

If you are on a multi destination trip please list all the countries visited?

____

____

____

Dual Insurance Details

Please confirm if you or anyone else claiming has any other insurance policy that may cover this event. This may include cover provided by your household insurer, Credit Card Company, bank account or travel booking agent.

Yes	No

If Yes please provide details of the other company including where relevant full contact details, policy number or bank account number.

Please note there is an agreement between most travel and household insures that if we seek a contribution of any outlay made by Accident & Health Claims Services LLP then your "No-Claims" status will not be impacted.

For Medical Related Claims:

I authorise any doctor, hospital or other organisation or person having any records or information concerning my medical history or treatment to furnish such records or information as may be requested by Accident & Health Claims Services Limited. I understand that in executing this authorisation, I waive the right for such information/records to be privileged. I am also aware that such information/records are relevant in the evaluation of my claim and that non-submission could prejudice my claim. A photocopy of this authorisation shall be considered as effective and valid as the original.

Name

Signed

Relationship to claimant if applicable

Dated

If your claim is agreed how would you like to be paid?

- Please note payment directly into your bank account will be quicker than sending a cheque.
- If the payee name differs from the Assured as stated on the Schedule of Insurance a mandate on the Assured's letter headed paper will be required before payment can be issued.
- For payments into non UK bank accounts we can only arrange payment into the final receiving bank and not through an intermediary.

Preferred Payment Method		Bank Details	
Cheque	☐	Confirm Payee:	
BACS (UK Bank Accounts only)	☐	Name of Account Holder:	
		Account Number:	
		Sort Code	
Wire Transfer (payments into Non UK bank Accounts)	☐	Bank Swift Code: For payments to all countries.	
		Bank IBAN : For payments to all European countries.	
		Account Number:	
		Name of Account Holder:	
		Country of Bank:	

Declaration

All Claimants over the age of 16 must sign below otherwise the claim form will need to be returned to you and this will result in a delay in handling your claim.

It is against the law to submit a fraudulent insurance claim which includes deliberately exaggerated claims. All types of fraud are taken seriously and if your claim if found to be in any way fraudulent then the claim will be declined and the Underwriters of the policy reserve the right to pursue a recovery by the use of civil action.

- I/We hereby declare that all information, documents and answers to questions given on this claim form are correct and true to the best of my/our knowledge. I/We have not omitted any information which would affect the Underwriters judgment of the claim.
- I confirm that where a claim or claims are made on behalf of others, I have the other claimant’s full authority to act on their behalf and I confirm that I understand that neither Accident & Health Claims Services LLP nor the Underwriters of the Insurance will accept any responsibility if any payments are not distributed proportionately to the persons concerned.
- I/We understand that the information on this form will be passed to or used by Accident & Health Claims Services LLP for my insurance; this includes underwriting, processing, handling claims and preventing fraud. This could include passing details to agents or other Insurers.
- I/We subrogate all rights of recovery to Accident & Health Claims Services LLP and also consent to them seeking reimbursement of any claims expenses paid by them.
- I/We agree to Accident & Health Claims Services LLP to contact my household insurers or medical insurers or other travel insurers regarding a contribution.

I agree that I have read and fully understood the above declarations.

Claimants Name	Claimant Signature	Date Signed

Medical Expenses Claim Form

Please indicate your reason for claiming:-

Illness	☐	Injury	☐

Date and time illness or injury occurred:	dd/mm/yy HH:MM
Name of clinic or hospital:	
Treating Dr's name:	
Date and time of admission (if applicable):	dd/mm/yy HH:MM
Date and time of discharge (if applicable):	dd/mm/yy HH:MM
Did you contact the Emergency Service Company?	Y/N
If yes, please confirm the date and time you first contacted them. If contact was not made please confirm why on a separate sheet of paper.	dd/mm/yy HH:MM

Please provide full details of the illness or injury suffered and any other relevant information. If you have suffered an injury as a result of an accident caused by a third party, please provide their full details.

Previous Medical History

Have you suffered from the condition that has resulted in the submission of this claim, or related condition previously?

Y/N

If Yes, we may need to contact your usual Doctor for further information and to enable us to do so, we shall require the declaration on the second page of the claim form, headed 'Medical Related Claims' to be completed. Please be aware that any fee charged by the Doctor for providing the necessary information is at your own expense.

Expenses Incurred

Please list the medical expenses you wish to claim for (continue on a separate piece of paper if necessary).

Date	Description of Expense	Invoice From	Amount paid and currency	Sterling Equivalent	Paid Y/N

Travellers from the UK who are eligible are entitled to free or reduced costs for emergency medical treatment in the other European Economic Area (EEA) countries or Switzerland. If your claim originates from one of these countries please complete the following: -

Was treatment sought under the European Health Insurance Card (EHIC)?	Y/N
Were you in possession of a European Health Insurance Card (EHIC) at the time of the claim?	Y/N

If Yes, please complete the DSS Consent Form attached. Failure to do so may delay the processing of your claim.

If your claim is for medical treatment received in Australia, please complete the following: -

Did you register with Medicare? If Yes please return a copy of the registration papers.	Y/N

If your accident is as a result of a winter sports activity, please complete the following: -

Were you:	Skiing	Y/N
	Snowboarding	Y/N
	Other	Y/N

If other, please provide full details of the activity you were taking part in.

Were you off-piste? Y/N

Are you a member of a private medical health scheme such as Bupa, AXA PPP or similar organisation? Y/N

If Yes, please supply the name of the organisation, address and membership or group number:

Name:	
Address:	
Membership number:	

Documents required to support a Medical and Additional Expenses claim

- Original invoices to support the amount claimed.
- Medical report from the treating Doctor.
- Proof of the admission and discharge dates for inpatient cases.
- For claims originating in the EEA and Switzerland, the signed consent form.
- For claims where you think a third party is at fault, any photographs of the accident location and the relevant police report if applicable.
- If you are claiming for medication in France, the Feuille de Soins must be signed by you on the reverse.