



Medical Expenses Claim Form

Once completed, please return your claim form to:

Travel Claims
Claims International
PO Box 1037
Oakleigh House
Cardiff
CF11 1HU
United Kingdom

Thank you for notifying us of your claim.

Please complete this form and return to Claims International as soon as possible.

Please write in **BLOCK CAPITALS**

Please provide full supporting documentation to avoid delays in processing your claim.

Please state 'N/A' where a section is not applicable.

Company Details (The Insured):

Policy Number: _____

Company Name: _____

Company Address: _____

Postcode: _____ E-mail: _____

Telephone: _____ Fax: _____

Company Contact Name: _____

Claimant Details (The Insured Person):

Title	Full Name(s)	Date of Birth	Position Held

Claimant Address: _____

Postcode: _____ E-mail: _____

Telephone: _____ Fax: _____

Country of Residence _____

Employee Number: _____



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Address of Residence / Hotel: _____

Departure Date: _____ / ____ / ____ Return Date: _____ / ____ / ____

Purpose of Trip (delete as applicable): _____ Business / Pleasure

If Business (delete as applicable): _____ Clerical / Manual

Date & time of accident / illness: _____ / ____ / ____ Time: _____ AM/PM

If **accident**, please state fully:

(a) Where the accident occurred: _____

(b) How the accident occurred: _____

(c) The injuries sustained: _____

If **illness**, please provide full details: _____

Please state name and address of your General Practitioner in the UK: _____



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Have you ever suffered from this illness before: YES / NO

If YES, please provide full details with relevant dates: _____

PLEASE ALSO PROVIDE US WITH A LETTER FROM YOUR ATTENDING DOCTOR CONFIRMING THAT THERE WAS NO MEDICAL REASON FOR YOU NOT TO TRAVEL

Please state whether you were hospitalised: YES / NO

If YES, please advise the hospital address and the dates involved: _____

Admitted: _____ / / _____ Time: _____ AM/PM

Discharged: _____ / / _____ Time: _____ AM/PM

Have you previously claimed under this or a similar policy: YES / NO

If YES, please give details: _____

Are you covered under any group private medical scheme?
(i.e. BUPA / PPP or any similar scheme) YES / NO

If YES, please provide name, address and reference number of the company concerned: _____



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DETAILS OF EXPENSE: All accounts, bills, receipts, medical certificates, booking invoices, correspondence and any other documents relating to this claim should be forwarded.

Nature of Expense	Name & Address of Doctor or Hospital Admitted	Currency & Amount Being Claimed	Paid (Y/N)



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

If the payee name differs from the Insured name a mandate on the Insured's letter headed paper will be required before payment can be issued.

Please tick box to choose preferred method of payment.

Cheque: Confirm Payee: _____
or
Direct to your bank account: (UK bank account only)

Bank Name: _____

Branch Address: _____

Account Number: _____ Sort Code: _____

Account in the name of: _____

Declaration – This must be signed.

I/We declare that the above statements are true and correct to the best of my/our 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.

The insurance industry operates a number of anti-fraud initiatives. The information 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.

Signature: _____ Date: ____ / ____ / ____