

Claims International Limited

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(calls may be monitored or recorded for quality purposes)

Registered in England No: 2134239 Registered Office: 14th Floor, Leon House, 201-241 High Street, Croydon CR9 1ER, UK

WEB CLAIM

Dear Sir/Madam

MEDICAL EXPENSES AND CURTAILMENT CLAIM FORM

Here is your claim form as requested. Please complete it fully and return to us.

PLEASE ENSURE YOU SIGN AND DATE THE FORM ON THE FINAL PAGE – FAILURE TO DO SO WILL DELAY YOUR CLAIM.

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form. **Thank you.**

VERY IMPORTANT

Please ensure you enclose the following **ORIGINAL** (not photocopied) documents (if not already sent).

- | | | | | | |
|--|---------------------------------|--------------------------------|--|---------------------------------|--------------------------------|
| a) Proof of insurance, such as the numbered certificate or validation receipt or tour operators invoice showing insurance. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | f) Original receipts for costs incurred. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| b) Medical evidence to support details of illness or injury. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | g) If the claimant was a hospital in-patient, evidence to show admission and discharge dates. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| c) Original travel tickets (ie flight coupon/ferry/coach tickets) | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | h) If the holiday was curtailed any additional travel tickets (flight coupons/ferry tickets/ rail tickets/taxi costs). | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| d) In cases of death, a photocopy of the death certificate is required. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | i) If travelled to an EEA country the attached Medical Benefits Form (see notes below). | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| e) The holiday booking invoice or other documents issued as evidence of holiday/trip cost and dates. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | j) Any accident report form or police report if applicable. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |

CLAIM FORM NOTES

Travellers from the UK, who are eligible, are entitled to free or reduced-cost emergency medical treatment in the other EEA (European Economic Area) countries (which includes the European Union states). If you are in possession of an EHIC (European Health Insurance Card), please do not send it through to us. Regardless of whether you have an EHIC or not, please complete the attached Medical Benefits Form. Failure to do so may delay the processing of your claim.

TELECLAIMS

If you have no objection, in an effort to promote speedier and more customer-friendly claims handling we may find it easier to telephone you during the course of our normal working hours to discuss your claim and/or request further details. Please advise us of any relevant numbers on which you can be reached:

..... or

CLEAR BLOCK CAPITALS MUST BE USED PLEASE

<p>1. Claimant's title: MR/MRS/MISS/MS Forenames: Surname:</p>	<p>6. a. The date of policy issue (this is important): DAY: MONTH: YEAR:</p>
<p>2. Address: Post Code:</p>	<p>b. The policy no. and policy prefix (if relevant): PREFIX: NO:</p>
<p>3. Telephone No. Home: Mobile: Email address:</p>	<p>7. The name of the travel agent who issued the insurance:</p>
<p>4. Occupation: Date of Birth:</p>	<p>8. The period of your holiday/trip giving total number of days. From: To: Total no. of days:</p>
<p>5. The destination and country of this holiday/trip:</p>	<p>9. No. of people covered by this policy:</p>
	<p>10. The tour operator from whose brochure you booked (if relevant):</p>
	<p>11. The day on which your holiday/trip was first booked: DAY: MONTH: YEAR:</p>

12. Please tell us the date and resort in which the injury was sustained or the illness contracted:
Date: Resort: Country:

13. Does the incident relate to an illness? Yes No If yes, please provide a full description:
.....
.....

14. Does the incident relate to an injury? Yes No If yes, please answer the following:

a) Please provide a full description of the injury

b) Please provide full details of the circumstances surrounding the accident and attach any documentary evidence/reports

c) Do you consider anyone to blame for the accident? Yes No
If yes i) Please provide name, address etc

ii) Please detail the reasons you consider this person(s) to blame

15. If the claim for illness or injury is for the curtailment of the trip, please provide full details of the reason for the curtailment and supply documentary evidence

16. Does your claim involve a medical condition for which previous advice/treatment has been given? Yes No
If yes, was this condition declared? Yes No
If yes, please quote your reference number

17. Was the medical assistance company contacted? Yes No
If yes, what assistance was provided?
Name of assistance service:
Assistance provided:
Reference if known:

18. If you were admitted to hospital, please advise:
Name of hospital:
Date admitted:
Date discharged:
Total number of full days as in-patient:

19. If the curtailment was due to death or illness in the United Kingdom please advise the name of the person and the relationship to the claimant:
Name:.....
Relationship:

CURTAILMENT ONLY

IMPORTANT

The circumstance leading to the curtailment of your holiday must be supported by independent documentary evidence from the attending medical practitioner or other relevant third party.

Names of all persons curtailing	Total holiday cost per person excluding insurance premium
.....
.....
.....
.....
.....

Date you returned / /
Date you should have returned / /

OFFICE USE ONLY	
Curtailment	
Cost per day	
No. of days lost	FOR OFFICE USE ONLY
Gross £	
Excess total	
Net £	

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION

PRIOR TO RETURNING THE CLAIM FORM PLEASE STUDY THE POLICY WORDING AND READ THE TERMS AND CONDITIONS AS THEY RELATE TO YOUR CLAIM.

PLEASE NOTE NEITHER WE NOR INSURERS ARE RESPONSIBLE FOR THE COSTS OF OBTAINING DOCUMENTATION IN SUPPORT OF THE CLAIM

WARNING

THE MAKING OF A FRAUDULENT OR KNOWINGLY EXAGGERATED CLAIM IS A CRIMINAL OFFENCE AND COULD RENDER THE OFFENDER LIABLE TO PROSECUTION.

THE INFORMATION ON THIS FORM WILL BE USED BY YOUR INSURER TO DEAL WITH ANY CLAIM. YOUR INSURER MAY ALSO PASS THIS AND ANY OTHER INFORMATION TO OTHER INSURERS AND ORGANISATIONS INVOLVED IN DEALING WITH ANY CLAIM. INSURERS ALSO SHARE INFORMATION TO PREVENT FRAUD.

DECLARATION:

I/We declare that to the best of my/our knowledge and belief all information as stated herein is correct and that the company is subrogated with all rights I/we may have against a third party. Furthermore, by signing this documentation the patient also consents to Claims International Limited seeking reimbursement of medical expenses paid by them arising out of medical treatment received from the Department of Social Security and any relevant authority related thereto.

I/We have not withheld any information from insurers within my/our knowledge connected with this claim.

I/We agree to provide further information or documentation as may be reasonably required.

I subrogate and assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever else is necessary to secure such rights.

SIGNATURE OF CLAIMANT: DATE:

Medical Benefits

The Pension Service
Tyneview Park
Newcastle Upon Tyne
England NE98 1BA

Application for a refund of medical expenses

• Part 1 About the Policyholder (Please complete in capital letters)

1. Surname or family name	<input type="text" value="Mr/Mrs/Miss/Ms"/>
2. Forenames in full	<input type="text"/>
3. Date of birth	<input type="text" value="/ /"/>
4. National Insurance Number	<input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/> <input type="text" value=""/>
5. NHS Number	<input type="text"/>

If you have a European Health Insurance Card (EHIC) please complete parts 6,7 and 8

6. Personal Identification Number (Box 6 of the European Health Insurance Card)	<input type="text"/>
7. EHIC Details (Box 8 on the European Health Insurance Card)	<input type="text"/>
8. EHIC Expiry Date	<input type="text"/>
9. Nationality (If you are a Non-EEA National you must supply evidence of your right to reside in the UK)	<input type="text"/>
10. Present address	<input type="text"/> <input type="text"/> <input type="text" value="Postcode"/>
11. A daytime contact number	<input type="text"/>

12. Are you a refugee or stateless person?	Yes	<input type="radio"/>
	No	<input type="radio"/>

Tell us :

The dates you were abroad	<input type="text"/>
In which country and town the expenses were incurred	<input type="text"/>

• Part 2 Dependants

(Please complete if expenses were incurred by the dependant)

Dependant 1

1. Surname or family name

Mr/Mrs/Miss/Ms

2. Forenames in full

3. Date of birth

/ /

4. National Insurance Number

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5. NHS Number

If you have a European Health Insurance Card (EHIC) please complete parts 6,7 and 8

6. Personal Identification Number
(Box 6 of the European Health Insurance Card)

7. EHIC Details
(Box 8 on the European Health Insurance Card)

8. EHIC Expiry Date

9. Nationality
(If you are a Non-EEA National you must
supply evidence of your right to reside
in the UK)

10. Present address

Postcode

Dependant 2

1. Surname or family name

Mr/Mrs/Miss/Ms

2. Forenames in full

3. Date of birth

/ /

4. National Insurance Number

--	--	--	--	--	--	--	--	--

5. NHS Number

**If you have a European Health Insurance Card (EHIC)
please complete parts 6,7 and 8**

6. Personal Identification Number
(Box 6 of the European Health Insurance Card)

7. EHIC Details
(Box 8 on the European Health Insurance Card)

8. EHIC Expiry Date

9. Nationality
(If you are a Non-EEA National you must
supply evidence of your right to reside
in the UK)

10. Present address

Postcode

Dependant 3

1. Surname or family name

Mr/Mrs/Miss/Ms

2. Forenames in full

3. Date of birth

/ /

4. National Insurance Number

□ □ □ □ □ □ □ □ □ □

5. NHS Number

**If you have a European Health Insurance Card (EHIC)
please complete parts 6,7 and 8**

6. Personal Identification Number
(Box 6 of the European Health Insurance Card)

7. EHIC Details
(Box 8 on the European Health Insurance Card)

8. EHIC Expiry Date

9. Nationality
(If you are a Non-EEA National you must supply evidence of your right to reside in the UK)

10. Present address

Postcode

Dependant 4

1. Surname or family name

Mr/Mrs/Miss/Ms

2. Forenames in full

3. Date of birth

/ /

4. National Insurance Number

--	--	--	--	--	--	--	--	--

5. NHS Number

**If you have a European Health Insurance Card (EHIC)
please complete parts 6,7 and 8**

6. Personal Identification Number
(Box 6 of the European Health Insurance Card)

7. EHIC Details
(Box 8 on the European Health Insurance Card)

8. EHIC Expiry Date

9. Nationality
(If you are a Non-EEA National you must
supply evidence of your right to reside
in the UK)

10. Present address

Postcode

• **Part 3 What was the reason for your visit**

Holiday (If you have ticked this box please go to part 4)

Working abroad

Please tell us:

Were you working abroad when the expenses were incurred?

Yes No

If yes, was this a UK employer or were you working in continuation of your self-employment in the UK?

Yes No

If a UK employer:

What is their full name and address?

Were they paying compulsory Class 1 or Class 2 contributions to the UK National Insurance Scheme?

Yes No

Please send either :

Copy of Form E101 issued by the Inland Revenue

Or

Pay statement/P60 covering the period of treatment

Studying Abroad

Please tell us:

the name and address of your college

How long will/did your studies abroad last? (Please state the full period not just the period to date)

From To

Were/are the studies part of a recognised UK course, that leads to a UK qualification?

Yes No

If yes, please supply photocopied evidence

- **Part 4 Disclaimer**

I hereby consent to Claims International Ltd seeking reimbursement of medical expenses paid by them arising out of medical treatment received in (country)..... on/from (date).....

Signature

Do not use block letters

Date

Full Name of Person signing disclaimer