

Travel Claim Form

To help us deal with your claim quickly, please follow these guide lines

- 1) Complete a separate claim form for each claim and for each insured person.
- 2) Please ensure all sections of the claim form have been completed.
- 3) Proof of travel has been provided (e.g.: email confirmation of trip, booking invoices, tickets).
- 4) All requested information has been enclosed.

A. Insured Details

Name of Insured: _____ Policy Number: _____
 Mailing Address: _____
 Postcode: _____ Country: _____
 Telephone No: _____ E-mail: _____
 Group Name: _____ Was the purpose of the journey for: Holiday Business
 Dates of Journey: From: _____ To: _____

B. Medical Expenses

- 1) Please provide all medical invoices and receipts that you wish to claim for.
- 2) To be completed by the treating physician ONLY.

Please state the date on which the patient first consulted you: _____
 Address: _____ Telephone No: _____
 _____ Fascimile: _____
 _____ E-mail: _____

Please give your diagnosis of the illness / injury sustained by the claimant: _____

Will the illness / injury require further follow-up treatment? NO YES
 If YES, please give details. _____

Please give a brief history of this or any other related condition with dates on which any previous treatment took place.
 Date: _____ Nature of condition: _____

Have you any reason to believe that treatment for the same condition has been given previously? NO YES
 If YES, please give details. _____

C. Cancellation or Curtailment

When was the journey booked? _____ Amount claimed: _____
 When was the journey cancelled or curtailed? _____
 Please provide a detailed explanation of why the journey was cancelled / curtailed: _____

If the journey was cancelled due to illness / injury, we will require written confirmation from the General Practitioner that the insured person was unfit to travel. If the journey was cancelled due to illness / injury of a third party, we will require written confirmation from the third party's General Practitioner that the insured person was unfit to travel.

Please provide the cancellation invoice.

D. Travel Delay / Missed Departure

Reason for delayed / missed departure: _____

1) Travel Delay

Schedule date and time of departure: _____

Actual date and time of departure: _____

Number of hours delayed: _____

2) Missed Departure:

Point of departure: _____ Point of missed connection: _____

Please confirm how you recommenced trip: _____

Amount claimed: _____

Please provide documentation in support of the delay / missed departure (e.g. evidence from the travel operator / airline / ferry etc) and other supporting documentation.

E. Personal Accident

Please state the date on which the insured sustained injured or in the event of a fatality, when death occurred. _____

Please give the insured person's name, address and contact telephone number. _____

Address: _____ Telephone No: _____

_____ Facsimile: _____

_____ E-mail: _____

Please detail the nature of the loss or how death occurred.

Was the injury or cause of death as a result of natural causes? NO YES

If YES, please give details. _____

In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to the HealthCare International Claims Administration Office.

F. Loss of Passport

Please confirm where the passport was lost: _____

Please provide details and the expenses incurred in replacing the passport with supporting evidence.

G. Baggage, Personal Effects and Money

Date of loss or damage: _____ Time: _____

Please provide a detailed description of how the loss damaged occurred, including the location: _____

Please confirm where the loss / damage was reported to and which authority (e.g. police, airline, hotel etc): _____

Full description of item(s) and where they were purchased, price paid and cost now: _____

Amount Claimed: _____

If the loss occurred at the airport or on the aircraft, we will need the property irregularity report.

Please provide proof of the original purchase / ownership i.e. receipts, photographs, valuations, instructions manuals, confirmation from the authority.

Please note that we may make a deduction on wear and tear.

H. Other Types of Insurance

Does the insured person have any other type of insurance (e.g. medical, travel, household)? Yes No

Please provide us with the insurance details including name, address and policy no: _____

If yes have these insurers been notified? Yes No

Was an EHIC taken on the trip? Yes No Was this presented to the hospital / doctor? Yes No

Please send a copy of your EHIC card with this claim form.

F. Payment Details

In this section, you have 2 options in which we can deal with your reimbursement; either to pay you directly or your Provider of Medical Services (e.g. Hospital, Specialist). Please choose which method you would prefer along with any banking details if relevant.

Option 1

Payment direct to policyholder Payment in invoice currency Other currency (please specify) _____

Account Beneficiary Name: _____ Sort / Branch code: _____

Name of bank: _____ Account No. / IBAN: _____

Address of bank: _____ SWIFT code: _____

Option 2

Payment to Provider of Medical Service Please tick if direct billing has been previously agreed with Claims Dept.

Please return this form with all original supporting documentation including original bills/invoices and a copy of the policy document to:

HealthCare International
HCI 24:7 Claims Administration Office
95 Cromwell Road
London
SW7 4DL
United Kingdom

Tel : + 44 (0)20 7590 8816
Fax : + 44 (0)20 7590 8819
e-mail : claims@healthcareinternational.com

Signature of Treating Physician: _____

Date: _____

The confidentiality of patient and member information is of paramount concern to HealthCare International. HealthCare International fully complies with European Data Protection Legislation and International Medical Confidentiality Guidelines. You have the right to access the personal data that is held about you. You also have the right to request that we amend or delete any information which you believe is inaccurate or out of date.

Doctor's stamp

If you are not completely satisfied with the level of service received or the outcome of a claim from HealthCare International then please contact our Customer Care Team by email, customer-care@healthcareinternational.com or telephone +44 (0)207 590 8801. They will be happy to discuss this with you.

Please Send Claim Form To The HealthCare International Claims Administration Office