

Claim form for Curtailment / Medical and other expenses

Claim form Reference : IMECF100

We are pleased to enclose a claim form as requested.

Most delays in settling claims arise because claim forms are not fully completed or requested documents are not sent to us. We would therefore ask you to answer all questions fully and ensure all requested documentation is enclosed upon return of this claim form.

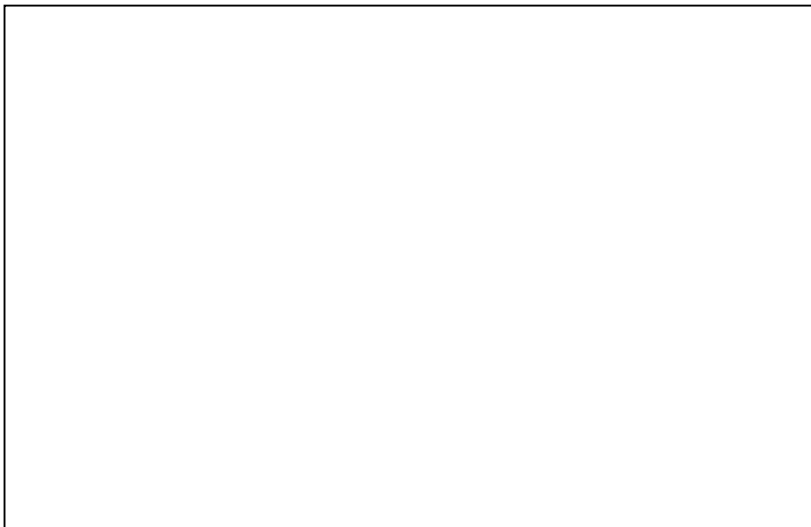
Please remember to read and sign the declaration, failure to sign the declaration will delay the assessment of your claim.

Please also remember to read and sign the Consent to medical reports section and have your General practitioner complete the report on the back page.

Please refer to the guidance notes for details of documentation we require.

If you find you do not have sufficient room to answer any question in full or you think you have additional information you feel is pertinent to your claim please use additional paper remembering to sign and date each sheet. Please indicate the number of additional pages attached to the claim form below the declaration.

Please return the completed form to your Insurance Broker or the office detailed below.

A large, empty rectangular box with a thin black border, occupying the lower half of the page. It is likely intended for the claimant to provide contact information for their insurance broker or to indicate the number of additional pages attached to the claim form.

Thank you for your co-operation.

Claim form for Curtailment / Medical and other expenses

Guidance Notes

Please note that if you are unable to supply any of the evidence we request, you should include a separate covering note explaining this. This will enable us to deal with your claim promptly.

In all cases, original documents must be provided. We are unable to accept photocopies (unless stated).

Please provide the following for all claims:

- The Tour Operator’s, Travel agents or Carriers Booking Invoice.
- Any tickets (used or unused) that relate to this travel.
- A copy of your Certificate of Insurance or Insurance Schedule.
- The medical certificate on the back of this claim form must be completed by the usual medical practitioner of the ill/injured/deceased person. If the claim form is returned and the medical certificate is not completed, we reserve the right to require its completion at a later stage.

For Medical and other Expenses (including the additional cost of return to the United Kingdom) claims the following should be provided:

- Invoices from service providers showing charges made against you, together with all receipts you received confirming payment.
- If you returned earlier or later than planned you should submit the medical certificate issued by the doctor who treated you abroad showing that your return was necessary on medical grounds.
- If you received treatment in an EEC country you should submit a completed E111 form which can be obtained from your local Post Office. You must also complete and sign the disclaimer section on the claim form.

For Curtailment claims the following should be provided:

- The medical certificate issued by the doctor who treated you abroad showing the medical need to return home earlier than planned.

Check List

The following is provided for your convenience to enable you to check that you have sent the appropriate information to us.

Booking invoice	<input type="radio"/>	Claim Form	<input type="radio"/>
Medical Certificate completed	<input type="radio"/>	Death certificate	<input type="radio"/>
Insurance certificate	<input type="radio"/>	All used/unused Tickets	<input type="radio"/>
Medical certificate obtained abroad	<input type="radio"/>	Expense receipts	<input type="radio"/>
E111	<input type="radio"/>	Claim form	<input type="radio"/>
Date claim from posted	<input type="text"/>		

Policy Number _____ / _____	Date Issued _____	
Insurance issued by _____		
(agent's name and address) _____		
Date Trip Booked _____	Date of Departure _____	Date of Return _____

Insured Person's Surname _____	Initials _____	Title (Mr/Mrs etc) _____	Date of Birth _____	
Name of Policyholder (if different from Insured Person) _____				
Address for correspondence _____				

Postcode _____				Occupation _____
Telephone Number (home) _____		Telephone Number (business) _____		
Fax Number _____		Email address _____		

Name of the ill/injured person _____	Date of birth _____	
Details of illness/injury suffered _____		

Date illness/injury commenced _____		
Was the 24 hour emergency service contacted? YES / NO If YES please confirm by who _____		
_____ and date of initial contact _____		
If the injury was the result of an accident please give full details including dates and the names of any other parties involved with their Insurance details if known. _____		

Date and time of admission to hospital _____		Date and time of discharge _____
Name and address of Hospital _____		

Did you return from your holiday earlier then planned?	YES/NO	If YES on what date _____
Are you claiming for any unused accommodation or travel?	YES/NO	If YES please give details _____



MEDICAL REPORT CONSENT FORM

Full name of Claimant _____ Date of Birth _____

Full name of Patient if different from Claimant _____

Date of Birth _____

Address: _____

General Practitioner _____ Address _____

Specialist _____ Address _____

I hereby consent to a medical report or my records being supplied in confidence to the Insurers Medical Adviser by the above named doctor(s) or their nominated deputy. I understand that it may be necessary for the Insurers or their representatives to discuss some of these matters in the strictest confidence with their personnel in order to assess the claim being made under the relevant policy/policies.

I understand my rights under the Access to Medical Reports act 1988 and have read the summary of my principal rights under this act (please see overleaf).

Delete where inapplicable

I DO NOT wish to have access to the medical report or notes before they are supplied.

I DO wish to have access to the medical report or notes before they are supplied and understand that I have 21 days in which to make the necessary arrangements with my medical practitioner, who is entitled to charge a fee for this service.

I agree to be seen and examined by the Insurers Medical Adviser. I also understand that any information or opinions drawn from his examination of me may also be divulged to the Insurers (or agreed third parties) and also understand that this may be used in making underwriting and claims decisions.

A copy of this consent shall be valid as the original.

Signed _____

Date _____

ACCESS TO MEDICAL REPORTS 1988

This is a summary of your principal rights under the Act, which is concerned with reports provided for employment or insurance purposes by a medical practitioner who is, or has been, responsible for your care.

- Option A.** You may withhold your consent for the report from a medical practitioner.
- Option B.** You may consent to the application but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report. It will not be sent to you automatically).

The medical practitioner will be informed that you wish to have access to the report and will allow 21 days for you to see and approve it before it is supplied to the applicant. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that you consent to its being supplied.

When you see the report, if there is anything in it which you consider incorrect or misleading, you can request (but this request must be in writing) that the medical practitioner amend the report, but he/she is not obliged to do so. If the medical practitioner refuses to amend it, you may :

- i) withdraw consent for the report to be issued.
- ii) ask the medical practitioner to attach to the report a statement setting out your own views.
- iii) agree to the report being unchanged.

NOTE: The medical practitioner is not obliged to show you any parts of the report which he/she believes might cause serious harm to your physical or mental health or that of others, or which would reveal information about a third party or the identity of a third party who has supplied the practitioner with information about your health, unless the third party also consents. In those circumstances the medical practitioner will so inform you and your access to the report will be appropriately limited.

- Option C.** You may consent to the application for the report, but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made, and notify the medical practitioner in writing, he/she should be allowed 21 days to elapse after such notification so that you may arrange to have access to the report (if the report has not already been supplied before you change your mind).
- Option D.** Whether or not you do decide to seek access to the report before it is supplied, you have the right to seek access to it from the medical practitioner at any time up to six months after it was supplied.

Please note that where a copy of the medical report is supplied to you, the practitioner may charge a reasonable fee to cover the cost of supplying it.

Claimant details:

Name of Claimant _____
Name of Patient if different from Claimant _____ Patients Date of Birth _____
Relationship to Claimant _____

Doctor's Report

Dear Doctor,

The above named person has submitted a claim under their Travel Insurance Policy. In order for us to assess the claim we would be grateful if you would answer the questions below.

Name of person to whom this report refers (the patient) _____

Are you the patient's usual practitioner? YES / NO

How long have you acted in this capacity? _____ Years.

What is the precise nature of the condition, illness or injury that has caused a claim to be made under this policy?

When were you first consulted about this condition? _____

Has the patient suffered from the same or a similar condition in the past? YES / NO

If so please advise dates of all previous treatments _____

Has the patient been included on a waiting list for in-patient treatment for this condition? YES / NO

If so please advise the date they were put on the list _____

If the cancellation was due to pregnancy please advise: -

Date pregnancy was confirmed _____

Expected date of delivery _____

Did the patient consult you for permission to travel? YES / NO if YES please give date _____

If so did you consider the patient fit to travel at the time? YES / NO

What date did you advise the patient to cancel their holiday arrangement? _____

DECLARATION

I have examined the patient and/or his medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signed _____

Practice stamp:

Name _____

Qualification _____