CLAIM FORM FOR MEDICAL EXPENSES AND OTHER EXPENSES

Please note that we have to ensure that our claim form covers all types of claim. If you do not consider a question to be relevant to your circumstances please enter N/A next to the question

It is important that you make sure you carefully read the declaration at the end of the claim form and ensure that it is signed before returning the form to us, failure to sign will result in your claim form being returned to you.

POLICYHOLDER'S DETAILS

Policy Number_____

Start Date _____End date_____

Date insurance purchased_____

Mr / Mrs / Miss Forename_____Surname_____

Address_____

_____Post Code_____

Occupation_____ Date of Birth _____

Telephone Number_____ Email address_____

Date of Departure from Home_____ Anticipated/Scheduled Date of Return_____

Destination _____ Purpose of Trip_____

DETAILS OF YOUR HOLIDAY/JOURNEY

Date trip was booked/Arranged: _____ Destination: _____

Date Deposit was paid for holiday: _____ How much paid? £ _____

Date final balance was paid: _____ How much paid? £ _____

DETAILS OF ILL/INJURED PERSON

Name of Ill/Injured Person_____ Date of Birth _____

Details of Illness/Injury suffered _____

_____

If injury caused by accident please give full circumstances including the sport being practiced if applicable.

_____

_____

_____

Date Illness/Injury commenced _____

Was the 24 hour emergency service contacted? YES/NO

If 'Yes' please confirm by whom: _____ and

Date of initial contact: _____ Reference given (if any) _____

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 or discharge_____

Name and address of Hospital_____

_____

Did you return from your holiday earlier than planned? YES/NO

If YES on what date _____

Are you claiming for any unused accommodation or travel? YES/NO

If YES please give details _____

_____

_____

_____

EXPENSES INCURRED

Date expense incurred	Name of Provider	Was an EHIC presented?	Amount of expense (please state clearly the currency)	Paid by you?	**For office use only**

DISCLAIMER – The following should be completed and signed by those who incurred the medical expenses in an EU Country.

I hereby consent to Underwriters seeking reimbursement of medical expenses paid by them for medical

treatment received in _____(country) from an illness/injury which commenced on

_____ (Date).

Signature _____ Date _____

OTHER INSURANCE

Insurance companies have an agreement that if you hold two or more policies covering the same circumstances, each company will split the cost of the claim between them. It is a condition of your policy that you advise us if you have any other policies or have potential cover elsewhere. It is unlikely that you will lose any no claims bonuses attached to your other policies but if you have any concerns we suggest you contact the relevant insurer.

Do you have Private Health Insurance that covers you abroad? YES/NO

If YES please provide:

Name & address of Insurance Company _____

_____

Policy Number_____ Period _____

Do you have any other travel insurance cover (this could be included with your bank account or home insurance policy). For **Activity TopUp** policies it is essential that you provide details as this type of policy is only valid if you have travel insurance. If YES please provide:

Name & address of Insurance Company _____

_____

Policy Number_____ Period _____

PAYMENT DETAILS

Should a payment become due under your insurance policy, your Insurers' preferred method of settlement is by BACS transfer and if this is convenient to you please complete the following:

Account name:		Account number:	
Bank name:		Sort Code:	

Alternatively:-

Please advise to whom any settlement cheque due should be made payable_____

Data Protection

Please note that your personal information may be used for the purposes of insurance administration and claims handling by us, AXA XL, its associated companies, its co-insurers, the insured and its broker and other third parties advising us or otherwise relevant to the handling of your claim. Your personal information may be used by AXA XL and its reinsurer(s) and reinsurance broker(s) for any reinsurance claim made by them, for renewal purposes and for their management reporting and for internal and external audit.

It may also be used for statistical purposes, for fraud and crime prevention and may be disclosed to Lloyd's or regulatory bodies in connection with compliance with any regulatory rules or codes.

Your personal information may be transferred to any country, including those outside the European Economic Area, for any of these purposes.

DECLARATION

I understand that making a fraudulent claim or knowingly exaggerated claim or providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form is, to the best of my knowledge and belief, true in every respect and that the amounts claimed have not been refunded to me or claimed from any other source.

Signature _____ **Date:** _____

Name (Block Capitals) _____

Please us additional paper if the space on provided on this form is insufficient, please attach additional paper when submitting this form.

Number of additional pages attached: _____

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.

It is important that you provide evidence to support your claim and this should include but may not be limited to:-

- Original booking details (this will need to be from the provider)
- Receipts for any costs incurred
- A completed medical report attached (pages 5 & 6)

Your claim form and supporting documents can be scanned and returned to us by email to Starpeak.Claims@csal.co.uk or by post to the following address:-

CSA Ltd/Gallagher Bassett
48 Felaw Street
Ipswich
Suffolk
IP2 8PN

This form is to be completed by the duly qualified medical practitioner of the ill/injured person and at your own expense.

MEDICAL REPORT

Name of Patient: _____Patient's Date of Birth: _____

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

How long have you acted in this capacity: _____

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

_____

_____

What date did the patient first become aware of the illness/injury? _____

When was the patient first seen by any medical practitioner for this condition?_____

When you were first consulted about this condition (if different from above)?_____

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

If so please advise details and 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: _____

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

If claim was due to pregnancy please give**:**

Date pregnancy was confirmed_____Expected due date_____

If the claim is in relation to the death of your patient please provide:

Cause of Death_____

Date of Death_____

Date of onset of illness/injury that caused the death _____

Was the patient considered terminal YES / NO If 'Yes' the date terminal diagnosis given _____

If 'No' the date it became apparent that the patient might not survive _____

Please provide any additional information you think may assist with the claim made

_____

_____

Thank you for your time and assistance in this matter. Please carefully read and sign the declaration overleaf.

DOCTOR'S DECLARATION

I have examined the patient and/or their 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 _____

Name _____

Qualification _____

Date _____

Practice Stamp: (Please include address & telephone number if not on stamp)