

Claim Form - Medical Emergency

This is side 1 of 2

Claim reference number:

Please complete in **BLOCK CAPITALS** and in **BLACK INK**, and continue any answers on a separate sheet if necessary. If any sections on this or any related form are left blank or are unclear, your claim may be delayed.

Please ensure that you send in the **ORIGINAL** booking invoice that confirms your travel dates and who you were travelling with.

<p>1. Details of illness / accident (and diagnosis if known).</p>	<p>2. Date of onset: ___ / ___ / ___</p> <p>Country _____</p> <p>Place / resort _____</p> <p>Local time ___ : ___ am / pm</p>	<p>3. Was the Medical Assistance Company (as named in your policy) contacted?</p> <p style="text-align: center;">YES / NO</p> <p>If yes, please state:</p> <p>Name: _____</p> <p>Reference number: _____</p>
---	---	---

<p>4. Did you pay the policy excess in resort?</p> <p style="text-align: center;">YES / NO</p> <p>Amount paid: _____ (inc. currency)</p> <p>PLEASE SUBMIT RECEIPT</p>	<p>5. Have you been treated for this, or any associated or similar illness before?</p> <p style="text-align: center;">YES / NO</p> <p>If yes, please provide full details including method and dates of treatment, check-ups and medication taken WITHIN THE PAST 3 YEARS</p> <p style="text-align: center; font-size: small;">(Please note that we may need to approach your General Practitioner for further information)</p>
---	---

6. If you were admitted as an in-patient, please tell us:

The date of admission to the overseas hospital ___ / ___ / ___ Local time ___ : ___ am / pm

The date of discharge from the overseas hospital ___ / ___ / ___ Local time ___ : ___ am / pm

7. In the boxes below, please detail the amounts you are claiming. Both medical expenses which have already been paid and unpaid accounts and invoices need to be listed for consideration. If you are able to submit evidence of the rate of exchange at the time the treatment was paid, we will use this rate. Please continue on a separate sheet if necessary.

Date of treatment	Nature of expense i.e. doctor's fee, prescription etc	Name of provider i.e. doctor, ambulance, hospital etc	Amount paid (inc currency)	Has this bill been paid? (tick)		Method of payment: cash, cheque, credit card, debit card etc
				YES	NO	

Please enclose all original bills, receipts and invoices for treatment, whether paid or unpaid.

8. If you were travelling to an EEC country, do you hold an EHIC (European Health Insurance Card)? **YES / NO**

If yes, please attach a photocopy of your card.

P.T.O.

