# MEDICAL & OTHER EXPENSES CLAIM FORM

**Claim Number:** A claim number will be allocated once this form is returned

Please complete this form and email it to:
claims@truetraveller.com

**Date:**

**Please use the above address for ALL correspondence & quote the above Claim Number in ALL subsequent communication.**

**When the Claim Form is received we aim to process it in ten working days.**

This claim form is being provided to you as requested in order that you can make a claim for Medical & Other Expenses under the terms and conditions of your travel insurance policy.

If the claim relates to tragic circumstances such as a death, please accept our sincere condolences. In this event the name and address of the **CLAIMANT** *(please see question Q01 below)* should relate to the person with whom we should correspond. We regret that it is essential for a death certificate to be provided in these circumstances.

Below is a Document Check List – please ensure you provide the correct documentation when submitting your claim as failure to do so may cause delays.

We suggest you keep a copy of this claim form and other documents for your own records.

| **IMPORTANT DOCUMENT CHECK LIST**<br>Have you enclosed or previously provided the following **ORIGINAL** (not photocopy) documents? | ✓ **PLEASE TICK** | | | |
|---|---|---|---|---|
| | **Enclosed** | **Previously Sent** | **Not Available** | **Not Applicable** |
| **CERTIFICATE OF INSURANCE** (or other proof of payment of insurance premium i.e. the Tour Operators booking invoice) | | | | |
| **HOLIDAY BOOKING INVOICE** as issued by the booking Agent & Tour Operator (if applicable) | | | | |
| **ORIGINAL RECEIPTS** for any costs being claimed | | | | |
| **MEDICAL EVIDENCE** to support details of illness or injury | | | | |
| **DEATH CERTIFICATE** (if applicable) | | | | |
| **EVIDENCE OF HOSPITAL ADMISSION AND DISCHARGE** (only applicable if the Claimant was an in-patient in hospital) | | | | |
| **ORIGINAL TRAVEL TICKETS** (i.e. flight coupons/ferry tickets) | | | | |
| **ADDITIONAL TRAVEL TICKETS** (if applicable) | | | | |

**PLEASE ANSWER ALL QUESTIONS IN BLOCK CAPITALS – THANK YOU FOR YOUR CO-OPERATION**

## CLAIMANT DETAILS

**Q01.** Claimant's Details: Title: First Names: Surname:

**Q02.** Date of Birth: Present Age: **Q03.** Occupation:

**Q04.** Address:

Post Code:

**Q05.** Home Tel: Mob Tel: Work Tel:

E-mail:

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## HOLIDAY & INSURANCE DETAILS

**Q06.** Holiday booking date: Period from: to: Number of days:

**Q07.** Number of people in your party: **Q08.** Holiday Country & Destination:

**Q09.** Name of the travel agent who issued the policy: True Traveller

**Q10.** Travel Insurance Policy Number (as shown on your insurance schedule): AX

**Q11.** Policy issue Date ***(very important)***:

**Q12.** Method of payment for the holiday: Credit Card ☐ Debit Card ☐ Cheque ☐ Cash ☐ Other ☐

If credit card was used please provide details: Card Issuing Company:

## CLAIM DETAILS

**Q13.** Date, Time & place the injury or illness occurred: Date & Time: Place:

**Q14.** The nature of the injury or illness and the FULL circumstances in which it arose (especially in the case of an injury). Please continue on a separate sheet if necessary.

**Q15.** If injury, name and address of any witnesses:

**Q16.** Were the Assistance Company contacted YES ☐ NO ☐ If 'YES' please provide name of company:

Assistance Company Ref No (if known): What type of assistance did they provide?

**Q17.** Was the holiday representative involved YES ☐ NO ☐ If 'YES' please provide a copy of any report obtained

**Q18.** Were you admitted to hospital YES ☐ NO ☐ If 'YES' please advise the name of hospital: and other details below;

Date & Time of Admission: Date & Time of Discharge:

Total number of FULL 24 hour periods: Do you feel all the treatment you received in hospital was necessary and reasonable YES ☐ NO ☐

**Q19.** On what date did you return to the UK? Giving a total extended stay of days

**Q20.** What items are you claiming for? **Please complete the CLAIM EXPENSES SCHEDULE overleaf**

## E111 & OTHER INSURANCE & THIRD PARTY DETAILS

**Q21.** Did you obtain the form E111 or EHIC (European Health Insurance Card) from the DSS to entitle you to reduced medical costs in an EEC country and was this used? YES ☐ NO ☐ If you obtained the form, and still have it in your possession, please forward it to us: Form obtained: YES ☐ NO ☐ Form attached: YES ☐ NO ☐

**Q22.** Do you have any other medical insurance i.e. BUPA, PPP or Provincial Healthcare (Canada) that may cover these expenses? You may be able to reclaim your excess if you do. YES ☐ NO ☐ If 'Yes' please provide Policy Holder Name (if different):

Company Name & Address:

Membership Number: Policy Number:

**Q23.** Has this claim been submitted (or will it be) to the DSS or other insurer? YES ☐ NO ☐ Their ref (if known):

**Q24.** Was the injury or illness caused by another party? YES ☐ NO ☐ If 'YES' please provide the name and address of the other party and full reasons why you or your advisors consider they were to blame. Name & Address:

Reasons:

**Q25.** Has a claim been made against the other party named in Q24? YES ☐ NO ☐ If 'YES' please provide details and the name, address and reference of any company handling the matter on your behalf:

Reference:

## PREVIOUS CLAIMS

**Q26.** Have you or any other person named on this form ever made any previous claim for medical or other expenses against this or any other Insurer: YES ☐ NO ☐ *(Please continue on a separate sheet if necessary)*

a) Date: Incident:

Insurers/Adjuster: Reference:

a) Date: Incident:

Insurers/Adjuster: Reference:

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## Q20. CLAIM EXPENSES SCHEDULE

| Nature of Expense | Name of Supplier | Currency | Amount | ✓ *Please Tick if You Paid This* | ✓ *Please Tick if Unpaid & You Want Us To Settle Direct* |
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| | ***TOTALS*** | | | | |

## POLICY EXCESS - IMPORTANT!

The Policy Excess is the amount deductible from each and every claim unless an Excess Waiver applies.

If you require us to pay any bills direct, please confirm below whether the Policy Excess was paid and submit a receipt to show the payment.

If you do not have an Excess Waiver and did not pay the Policy Excess to the Doctor/Hospital at the time of treatment then please remit a cheque payable to 'The True Traveller Limited' for the appropriate sum *(please refer to your Policy Conditions for details of the amount)*.

Q.27 **Excess Paid?** YES ☐ NO ☐ If 'YES' to whom (name of Doctor/Hospital):

| Q.28 **Currency Used:** | Q.29 **Amount Paid:** |
|---|---|

Q.30 **Are further accounts to be submitted?** YES ☐ NO ☐ If 'YES' please provide details:

| Q.31 **To whom do you wish any personal payment to be made if different to the Claimant named in Q01?** | **Name:** |
|---|---|

## DATA PROTECTION NOTICE

True Traveller s.r.o. may use your information together with other information for underwriting, statistical analysis and claims. We may disclose your information to our service providers, agents and business partners for these purposes. We may also share your information with other interested parties and outside agencies to check the details and prevent fraudulent claims. We may also disclose your information to our agents to investigate or prevent fraud.

## DECLARATION – To Be Completed By The Claimant Aged Over 16 or the Next of Kin if Aged Under 16

True Traveller s.r.o., agents and business partners may contact anyone who can give them information relevant to my claim. I confirm that the information that I have given is true and if any of the information given by me (or anyone on my behalf) is incorrect, I agree that such inaccuracy may cause me to forfeit my rights under the policy.

In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.

**Payments:** Subject to admission of liability, we will make payment in favour of the claimant **(aged over 16)** as detailed in question 01 overleaf but if an alternative payee is required please state below.

I have read and fully understood the above declaration.

| Name | Signature | Date of Birth | Date of Signature |
|---|---|---|---|
| | | | |
| **Relationship to Claimant (if different)** | | | |

**PLEASE ENSURE THAT YOU RETAIN ORIGINAL DOCUMENTATION IF E-MAILING THIS FORM TO US.**

| PAYEE'S BANK DETAILS - UK RESIDENTS | | | | | |
|---|---|---|---|---|---|
| IF WE APPROVE YOUR CLAIM, WE CAN CREDIT THE MONEY DIRECT TO YOUR BANK ACCOUNT. THIS METHOD IS QUICKER, SAFER AND MORE RELIABLE THAN PAYMENT BY CHEQUE. IF YOU WOULD LIKE US TO DO THIS, PLEASE COMPLETE THE FOLLOWING: | | | | | |
| Name of your Bank/Building Society: | | | | | |
| Bank Sort Code: | | | | | |
| Account Number: | | | | | |
| Name of Account Holder(s): | | | | | |

If you are an EU resident and wish your funds to be transferred to your European Bank, please complete the following:

| | |
|---|---|
| Name and address of your Bank: | |
| The bank account number or International Bank Account Number (IBAN): | |
| The SWIFT Bank Identifier Code (SWIFTBIC): | |
| Name of Account Holder(s): | |