

Claims International Limited

Claims and Customer Service Managers

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(calls may be monitored or recorded for quality purposes)

Registered in England No: 2134239 Registered Office: 14th Floor, Leon House, 201-241 High Street, Croydon CR9 1ER, UK

IMPORTANT

Please keep a separate note of this claim reference number and quote it whenever you contact us.

Date:

Dear

MEDICAL EXPENSES AND CURTAILMENT CLAIM FORM

Here is your claim form as requested. Please complete it fully and return to us. If you have received an identical claim form please return this form indicating the claim reference number previously supplied.

Please check that we have correctly stated your name, initial(s), address and post code and amend if necessary.

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form. Thank you.

VERY IMPORTANT

Please ensure you enclose the following **ORIGINAL** (not photocopied) documents (if not already sent).

- | | | | | | |
|--|---------------------------------|--------------------------------|--|---------------------------------|--------------------------------|
| a) Proof of insurance, such as the numbered certificate or validation receipt or tour operators invoice showing insurance. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | f) Original receipts for costs incurred. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| b) Medical evidence to support details of illness or injury. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | g) If the claimant was a hospital in-patient, evidence to show admission and discharge dates. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| c) Original travel tickets (ie flight coupon/ferry/coach tickets) | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | h) If the holiday was curtailed any additional travel tickets (flight coupons/ferry tickets/ rail tickets/taxi costs). | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| d) In cases of death, a photocopy of the death certificate is required. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | i) Your E111 form (see notes below). | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| e) The holiday booking invoice or other documents issued as evidence of holiday/trip cost and dates. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | j) Any accident report form or police report if applicable. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |

CLAIM FORM NOTES

For claims involving medical expenses in an EC country, please enclose a copy of your E111 form (if obtained) as well as the original medical and prescription charge receipts (accompanied by the medical labels) which should be signed by the patient where applicable. Failure to do so may delay the processing of your claim.

TELECLAIMS

If you have no objection, in an effort to promote speedier and more customer-friendly claims handling we may find it easier to telephone you during the course of our normal working hours to discuss your claim and/or request further details. Please advise us of any relevant numbers on which you can be reached:

..... or

CLEAR BLOCK CAPITALS MUST BE USED PLEASE

1. Claimant's title: MR/MRS/MISS/MS Forenames: Surname:	6. a. The date of policy issue (this is important): DAY: MONTH: YEAR: b. The policy no. and policy prefix (if relevant): PREFIX: NO:
2. Address: Post Code:	7. The name of the travel agent who issued the insurance:
3. Telephone No. Daytime: Telephone No. Evening:	8. The period of your holiday/trip giving total number of days. From: To: Total no. of days:
4. Occupation: Age:	9. No. of people covered by this policy:
5. The destination and country of this holiday/trip:	10. The tour operator from whose brochure you booked (if relevant):
	11. The day on which your holiday/trip was first booked: DAY: MONTH: YEAR:
12. Please tell us the date and resort in which the injury was sustained or the illness contracted: Date: Resort: Country:	
13. Does the incident relate to an illness? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide a full description:	
14. Does the incident relate to an injury? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please answer the following: a) Please provide a full description of the injury b) Please provide full details of the circumstances surrounding the accident and attach any documentary evidence/reports c) Do you consider anyone to blame for the accident? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes i) Please provide name, address etc ii) Please detail the reasons you consider this person(s) to blame	
15. If the claim for illness or injury is for the curtailment of the trip, please provide full details of the reason for the curtailment and supply documentary evidence	
16. Does your claim involve a medical condition for which previous advice/treatment has been given? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, was this condition declared? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please quote your reference number	
17. Was the medical assistance company contacted? Yes <input type="checkbox"/> If yes, what assistance was provided? No <input type="checkbox"/> Name of assistance service: Assistance provided: Reference if known:	18. If you were admitted to hospital, please advise: Name of hospital: Date admitted: Date discharged: Total number of full days as in-patient:
19. If the curtailment was due to death or illness in the United Kingdom please advise the name of the person and the relationship to the claimant:	Name:..... Relationship:

CURTAILMENT ONLY

IMPORTANT

The circumstance leading to the curtailment of your holiday must be supported by independent documentary evidence from the attending medical practitioner or other relevant third party.

Names of all persons curtailing	Total holiday cost per person excluding insurance premium
.....
.....
.....
.....

Date you returned/...../.....

Date you should have returned/...../.....

OFFICE USE ONLY	
Curtailment	Cost per day
No. of days lost	FOR OFFICE USE ONLY
Gross £	Excess total
Nett £	

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION
PRIOR TO RETURNING THE CLAIM FORM PLEASE STUDY THE POLICY WORDING AND READ THE TERMS AND CONDITIONS AS THEY RELATE TO YOUR CLAIM.
PLEASE NOTE NEITHER WE NOR INSURERS ARE RESPONSIBLE FOR THE COSTS OF OBTAINING DOCUMENTATION IN SUPPORT OF THE CLAIM**

WARNING
THE MAKING OF A FRAUDULENT OR KNOWINGLY EXAGGERATED CLAIM IS A CRIMINAL OFFENCE AND COULD RENDER THE OFFENDER LIABLE TO PROSECUTION.
THE INFORMATION ON THIS FORM WILL BE USED BY YOUR INSURER TO DEAL WITH ANY CLAIM. YOUR INSURER MAY ALSO PASS THIS AND ANY OTHER INFORMATION TO OTHER INSURERS AND OGRANISATIONS INVOLVED IN DEALING WITH ANY CLAIM. INSURERS ALSO SHARE INFORMATION TO PREVENT FRAUD.

DECLARATION:
I/We declare that to the best of my/our knowledge and belief all information as stated herein is correct and that the company is subrogated with all rights I/we may have against a third party. Furthermore, by signing this documentation the patient also consents to Claims International Limited seeking reimbursement of medical expenses paid by them arising out of medical treatment received from the Department of Social Security and any relevant authority related thereto.
I/We have not withheld any information from insurers within my/our knowledge connected with this claim.
I/We agree to provide further information or documentation as may be reasonably required.
I subrogate and assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever else is necessary to secure such rights.

SIGNATURE OF CLAIMANT: DATE: