

## Medical Expenses Claim Form

Please return this claim form together with all supporting documentation to:

**Fly-sure Claims Dept, Birchin Court, 3rd Floor, 20 Birchin Lane, London EC3V 9DU Telephone 020 7739 3444**

Fly-Sure is arranged by Marcus Hearn, a trading name of Giles Insurance Brokers Ltd, Registered in Scotland, Registered Number 108909. Giles Insurance Brokers Ltd is authorised and regulated by the Financial Services Authority under reference 311786. This insurance is administered by FirstAssist Insurance Services Limited, Marshall's Court, Marshalls Road, Sutton, Surrey SM1 4DU. Registered in England and Wales. No 04617110. and is Authorised and Regulated by the Financial Services Authority, FSA Register No. is 310671. This insurance is underwritten by Great Lakes Reinsurance Office at Plantation Place, 30 Fenchurch Street, London, EC3M 3AJ. Registered in England and Wales No. 2189462 and is authorised and regulated by the Financial Services Authority. FSA Register No. is 202715

<b>Name</b>		<b>Certificate number</b>	
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Further to your request for a Claim Form, please complete it fully and return to us.

**PLEASE ENSURE YOU SIGN AND DATE THE FORM ON PAGE 4. ON QUESTIONS WHICH REQUIRE A YES/NO RESPONSE, PLEASE CIRCLE THE APPROPRIATE ANSWER. FAILURE TO DO SO COULD DELAY YOUR CLAIM.**

Please check that we have correctly stated your name, initial(s), address and postcode 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).**

	Attached (Please Tick)	
	Yes	No
<b>Proof of Insurance, such as your numbered policy schedule (and endorsements if your policy was endorsed) – photocopies are acceptable for annual policies</b>		
<b>Evidence of your trip such as the booking invoice or original travel tickets, showing travel dates/costs.</b>		
<b>Medical evidence to support details of illness or injury</b>		
<b>Original receipts for costs incurred.</b>		
<b>In cases of death, a photocopy of the death certificate is required.</b>		
<b>Evidence to show admission and discharge dates, if the claimant was a hospital inpatient.</b>		
<b>If the holiday was curtailed, please provide any additional travel tickets (flight coupons/ferry tickets/rail tickets/taxi costs).</b>		
<b>Any accident report form or police report, if applicable</b>		

**CLAIM FORM NOTES**

Travellers from the UK, who are eligible, are entitled to free or reduced-cost emergency medical treatment in the other EEA (European Economic Area) countries (which includes the European Union states). In order for us to seek reimbursement of our outlay, please could you provide the nationality and National Insurance number of the patient, where requested. If the patient is aged 16 or under, the details of their parent/guardian should be provided. If aged between 16 and 19 and still in full time education, a parent or guardian will need to provide these details. If you are in possession of an EHIC (European Health Insurance Card) please do not send it through to us.

**EMAIL AND TELECLAIMS**

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

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**CLEAR BLOCKED CAPITALS MUST BE USED PLEASE**

If different from addressee on Page 1, please confirm name and address of claimant

<b>Claimant's title</b> MR/MRS/MISS/MS		Please confirm your Certificate Number.		
<b>Forenames</b>				
<b>Surname</b>		Date of policy issue (this is important): DAY:                      MONTH:                      YEAR:		
<b>Address</b>				
<b>Postcode</b>		The period of your trip		
		From:	To:	
<b>Telephone No.</b> Daytime				
<b>Evening</b>		Total no. of days		
<b>Mobile</b>		The destination and country of this holiday/trip:		
<b>Email</b>				
<b>Occupation</b>		Number of people covered by this policy:		
<b>Date of Birth</b>		The tour operator from whose brochure you booked (if relevant):		
<b>Nationality</b> (see claim form notes on Page 1)		The day on which your trip was first booked: DAY:                      MONTH:                      YEAR:		
<b>National Insurance No:</b>				
Please tell us the date and resort in which the injury was sustained or illness contracted on the trip				
DATE	PLACE		COUNTRY	

## Medical Expenses Claim Form

<b>Does the incident relate to an illness contracted on the trip?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
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**If yes, please provide a full description:**

<b>Does the incident relate to an injury which occurred on the trip?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
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**If yes, please answer the following**

<b>Please provide a full description of the injury</b>	
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<b>Please provide full details of the circumstances surrounding the accident and attach any documentary evidence/reports</b>	
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<b>Do you consider anyone to blame for the accident?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
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<b>If yes, please provide name, address etc</b>	
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**Please detail the reasons you consider the person(s) to blame.**

**If the claim for illness or injury is for the curtailment of the trip, please provide full details of the reason for curtailment and supply documentary evidence.**

<b>Does your claim involve a medical condition for which previous advice/treatment has been given?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
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<b>If YES, was this condition declared?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
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<b>If YES, please quote your reference number.</b>	
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<b>Was the 24 hour Assistance company contacted?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
<b>If YES, what assistance was provided?</b>			
<b>Were you admitted to hospital?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
<b>Name of Hospital:</b>			
<b>Date admitted:</b>			
<b>Date discharged:</b>			
<b>Total number of days as an in-patient:</b>			
<b>If the curtailment was due to a bereavement in the United Kingdom, please advise the name of the person and the relationship to the claimant:</b>			
<b>Name</b>	<b>Relationship</b>		
<b>Was your trip extended?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
<b>If YES, please confirm why it was necessary to extend your stay:</b>			
<b>Date extended:</b>	<b>Number of days extended:</b>		
<b>Method of transport (please provide original travel tickets).</b>			
<b>Failure to answer this questions may delay your claim</b>			
<b>Are you a member of a private medical healthcare scheme such as BUPA, PPP or other similar organisation?</b>	YES	NO	PLEASE CIRCLE YOUR ANSWER
<b>If YES, please supply the name and address of the insurance company and Membership/Group number:</b>			
<b>Name</b>			
<b>Address</b>			

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<b>Membership/Group number:</b>	
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**Certain household contents/all risks policies provide travel cover. Do you have a household contents/all risks insurance policy or if you are living with your parents, do they have a policy?**

YES / NO

If yes, please supply the name and address of the insurance company and policy number:

<b>Name</b>		<b>Policy Number</b>	
<b>Address</b>			

**Do you have a bank account?**

**A bank account you hold may offer travel insurance cover as part of the benefits. Under no circumstances will your bank information be used other than to obtain a contribution from the travel insurance provider. This will not affect your bank account in any way. If yes, please provide the following details**

YES / NO

<b>Bank Account Name</b>		<b>Account Type (e.g. Premier)</b>	
<b>Account Number</b>		<b>Sort Code.</b>	

**Was a credit card used to pay all or part of the trip cost (certain credit cards may provide an element of travel cover)?**

YES / NO

If yes, please supply the following details

<b>Type of card:</b> (e.g Switch, Maestro, Mastercard, VISA etc)		<b>Name of Card issuer:</b> (e.g HSBC, Barclaycard etc)	
<b>Cardholders Name</b>		<b>Card Number.</b>	

## Medical Expenses Claim Form

### MEDICAL AND RELATED EXPENSES

**IMPORTANT**

Please attach **ORIGINAL** documents and invoices as photocopies are NOT acceptable. Please continue on a separate sheet, if necessary.

Type of expenses (e.g. doctors fee prescription, additional travel costs etc)	Name of provider (doctor, hospital etc)	Amount	Currency	Type of expenses (e.g. doctors fee prescription, additional travel costs etc)	
				PAID	UNPAID
<b>TOTAL</b>					

### 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 party.

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

Date you returned:	
Date you should have returned:	

## Medical Expenses Claim Form

### IMPORTANT NOTICE

In the event of this claim being successful and payment authorised in your favour, the amount being claimed can be paid directly into your bank account using Bank Automated Clearing Services (BACS).

In order to do this the Company will require your bank details. Please complete the information below:

<b>Name of Bank:</b>	
<b>Full Branch Address:</b>	
<b>Bank Account No.</b>	
<b>Sort Code</b>	
<b>Account Name:</b>	

### 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 the insurer and their agents are responsible for the cost 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 the Insurer and their agents to deal with any claim. The Insurer and their agents may also pass this and any other information to other insurers and organisations involved in dealing with any claim. The insurer and their agents may also share information to prevent fraud.

### PROTECTION OF YOUR PERSONAL DATA

The security of your personal information is very important to us and we are compliant with all current data protection legislation. All personal information that you supply to us either in respect of yourself or other individuals in connection with this claim will be treated in confidence by the insurer and their agents and will be held by us for the purpose of providing and administering your claim. This may involve the collection and processing of sensitive data (as defined in the Data Protection Act 1998) and if you complete an application form for our products and/or services you will be giving your consent to such information being processed by the Insurer and their agents.

It may be necessary to pass your personal and sensitive data to other companies for processing on behalf of the insurer and their agents. Some of these companies may be based outside Europe in countries which may not have the laws to protect your personal data, but in all cases the insurer and their agents will ensure that it is kept securely and only used for the purposes for which it was provided.

### INACCURATE DATA

If you believe that we are holding inaccurate information about you, please contact the team responsible for administering your claim and they will be happy to correct any errors.

### DECLARATION.

I/We declare that the information contained within this claim form is true and correct to the best of my/our knowledge and belief.

I/We have not withheld any information or documentation from insurers within my/our knowledge connected with the claim.

I/We agree to provide further information or documentation as may be reasonably required.

I/We assign to insurers all rights of recovery / salvage against any person or organisation and will do whatever else is necessary to secure such rights.

<b>SIGNATURE OF CLAIMANT:</b>		<b>DATE:</b>	
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