Travel & Wintersports Insurance
Claim Form
for

EMERGENCY MEDICAL EXPENSES AND CURTAILMENT

Please complete this form, send it with all supporting documents (documents may be sent on at a later date if necessary) to **International Medical Rescue, 15 East Links, Tollgate, Eastleigh, Hampshire, SO53 3TG** or claims@im-rescue.com It will usually take about a week to 10 days for a claim to be processed. You can also contact the claims department on 0345 122 3280 24 hours a day, 7 days a week.

Please note this must be done within 31 days of the date of loss. Late claims maybe repudiated.

The section below details the documents which you should enclose in order for us to deal with your claim. They must be **originals not photocopies** (other than for death). Please tick yes if enclosed and no if not.

a)	Medical evidence to support details of illness or injury.	Yes ☐	No ☐	f)	DSS form, if you travelled to an EEA country (see notes below).	Yes ☐	No ☐
b)	Original receipts for costs incurred.	Yes ☐	No ☐	g)	Any accident report form or police report if applicable.	Yes ☐	No ☐
c)	Proof of insurance, such as certificate to Tour Operators invoice.	Yes ☐	No ☐	h)	Holiday booking invoice or other documents issued as evidence of holiday/trip costs and dates.	Yes ☐	No ☐
d)	If the claimant was a hospital in-patient, evidence to show admission and discharge dates.	Yes ☐	No ☐	i)	In cases of death, a photocopy of the death certificate.	Yes ☐	No ☐
e)	Original travel tickets e.g. flight coupon, ferry/coach tickets. Plus, if repatriated early, additional travel tickets/costs.	Yes ☐	No ☐	j)	If claiming for medication in France the Feuille de Soins must be signed by you on the bottom right hand corner.	Yes ☐	No ☐

NOTES

1) Travellers from the UK, who are eligible, are entitled to free or reduced-costs for emergency medical treatment in the other EEA (European Economic Area) countries.

2) If you are in possession of an EHIC (European Health Insurance Card), please do not send this to us, only the DSS Form completed (whether you have an EHIC or not). Failure to do so may delay the processing of your claim.

SIGNATURE

Please sign and date the form on the final page.

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 numbers on which you can be reached:

……or……..

Failure to produce these documents above will delay the processing of your claim

PLEASE COMPLETE IN BLOCK CAPITALS

1. Claimant's title:
   Forenames: .....
   Surname: .....

2. Home Address:
   .....
   .....
   .....
   Post Code: .....
   Contact e-mail: .....

3. Contact Telephone No.
   Home:
   Mobile:

4. Occupation: Date of Birth:

5. The destination and country of this holiday/trip:

6. a. Date insurance issued:

   b. Policy ref no. or certificate no.

7. The period of your holiday/trip giving total number of days
   From: To:
   Total no. of days:

8. No. of people covered by the policy:

9. Name of tour operator from whose brochure you booked
   (if relevant):

10. Date holiday/trip booked:

11. Please tell us the date and resort in which the injury was sustained or the illness contracted:
    Date: ..... Resort: ..... Country: .....

12. Does the incident relate to an illness? Yes ☐ No ☐ If yes, please provide a full description:
    .....
    .....

13. Does the incident relate to an injury? Yes ☐ No ☐ 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) Were you : Skiing Yes ☐ No ☐
    Snowboarding Yes ☐ No ☐
    Other Yes ☐ No ☐
    Please describe .....
    .....
    d) Were you off piste? Yes ☐ No ☐
    e) Do you consider anyone to blame for the accident? Yes ☐ No ☐
    If yes i) Please provide name, address etc .....
    ii) Please show the reasons you believe this person(s) is to blame .....
    .....

16. Does your claim involve a medical condition for which previous advice/treatment has been given? Yes ☐ No ☐
    If yes, was this condition declared? Yes ☐ No ☐
    If yes, please quote your reference number .....

17. Did you obtain an EHIC from the DSS to entitle you to reduced medical costs in an EC country? Yes ☐ No ☐
    If yes, please enclose a copy.

18. Was the medical assistance company contacted? Yes ☐
    If yes, what assistance was provided? No ☐
    Name of assistance service: .....
    Assistance provided: .....
    .....
    Reference if known: .....

19. If you were admitted to hospital, please advise:
    Name of hospital: .....
    Date admitted: .....
    Date discharged: .....
    Total number of full days as in-patient: .....

PLEASE COMPLETE IN BLOCK CAPITALS

20. If the curtailment was due to death or illness of a relative or business colleague please advise the name of the person and the relationship to the claimant:

Name:……..Relationship:……

21. 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 .....

……

22. By what method of transport did you return to the UK? Was your trip curtailed or extended?

Date curtailed: ..... No. of days unused: .....

Date extended: ..... No. of days extended: .....

Method of transport: ..... (Please provide original travel tickets)

23. Are you a member of a private medical health scheme such as BUPA, PPP or other similar organisation? Yes ☐ No ☐

If yes, please supply the name of the organisation, address and membership/group number.

Name of organisation: .....

Address: .....

.....

Membership/Group No. .....

24. Certain household contents policies provide an element of travel insurance. Do you have a household contents 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.

Name: .....

Branch Address: .....

.....

Policy No: .....

25. Was either a credit or debit card used to pay for all or part of the holiday/trip cost? Yes ☐ No ☐

If yes, please supply the following information:

Type of card (eg. switch, mastercard etc.) ……Card issuer (eg. HSBC, Barclaycard etc.) ……

Cardholders name: ……..Card No. ……..

26. Do you have any other insurance which may cover this incident (eg Bank Account holder, employee schemes, travel agency etc)? Yes ☐ No ☐

If yes, please supply details of the policy(ies) ……

27. Please provide your bank account details:

Name of Account holder: .....

Name of Bank: .....

Account Number: .....

Sort Code: .....

Type of Account e.g. Gold: .....

MEDICAL AND RELATED EXPENSES

Please attach original documents and invoices, photocopies will not be acceptable.

Type of expenses (eg doctors fee, prescription, additional travel costs etc)	Name of provider (doctor, hospital etc)	Currency used and amount	Please indicate whether the bills are paid or unpaid (✓)		OFFICE USE ONLY
			UNPAID	PAID	
	TOTAL				

OFFICE USE ONLY	DATE EX RATE	GROSS £	X/S £ TOTAL £	NETT £

PLEASE COMPLETE IN BLOCK CAPITALS

CURTAILMENT CLAIMS

The circumstance leading your curtailment must be supported by independent evidence from an attending medical practitioner or other relevant person.

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

Date you returned or admitted to hospital: ……..

Date you should have returned**:** ……

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

FOR OFFICE USE ONLY

And Finally…..

To finalise your claim please sign the declaration below, however before doing so please read the following carefully:-

- Please study the policy wording and read the terms and conditions that relate to your claim.
- You are responsible for the cost of obtaining any documentation in support of your claim.
- This Insurance contains rights of subrogation and I confirm I assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever necessary to secure such rights.
- Information on this form will be used by insurers to deal with any claim. Insurers may also pass this and any other information to other insurers and organisations involved in dealing with any claim. Insurers also share information to prevent fraud.

DECLARATION

I declare that, to the best of my knowledge and belief, all information stated herein is correct and that the insurance company is subrogated with all rights I may have against any third party(s).

I consent to MPI Claims seeking reimbursement of medical expenses from The Pensions Service and any relevant authority arising out of medical treatment received.

I have not withheld any information from insurers within my knowledge connected with my claim.

I agree to provide further information or documentation that may be reasonably required.

SIGNATURE OF CLAIMANT: …… DATE:.....

SIGNATURE OF PARENT/GUARDIAN:…… DATE:……

RELATIONSHIP:……..

CONTACT NUMBER:…….....

CONTACT EMAIL:……..**Warning**

Making a fraudulent or knowingly exaggerated claim is a criminal offence and could render the offender liable to prosecution.

Copy

Please take a copy of this claim form and any attachments for your records and send the original with all supporting documents to **International Medical Rescue, 15 East Links, Tollgate, Eastleigh, Hampshire, SO53 3TG**.

Medical Benefits

DSS Consent Form

Department of Social Security
Pensions and Overseas Benefits Directorate
Tyneview Park
Whitley Road
Newcastle upon Tyne
NE98 1BA

Claim Ref:

Date:

I hereby consent to International Medical Rescue Limited seeking reimbursement of medical expenses paid by them on behalf of Insurers arising out of medical treatment received in _____ on ____/_____/20__ from various medical sources.

Signature: ……..Date……

Full Name of Patient……..……..

Date of Birth of patient:……..

National Insurance Number…….

National Health Service Number…….

European Health Insurance Card (EHIC) Number……..

Nationality……

If patient is under 16 years of age:

Full name of parent/guardian……

Date of birth of parent/guardian……

National Insurance Number……..

National Health Service Number…….

European Health Insurance Card (EHIC) Number……..

Nationality……