

travel insurance claim form

OVERSEAS MEDICAL, DENTAL AND RELATED EXPENSES

- Please ensure you provide all requested information and documentation
- Please keep a copy of your claim
- Usually we'll respond to your claim within 10 working days from the day we receive it

return address: Right Cover – claims team
PO Box 9386, Chelmsford, Essex, CM1 9BD

OFFICE USE ONLY: **NEW** **EXISTING**

Claim number:

Date received:

your details

Title First name

Surname

Date of birth Passport number

Occupation

Email address

Home address

County Postcode

Home phone Mobile

Work phone Fax

Name of your travelling companion Their contact number

your policy

Policy number Date issued

Travel agency name and location Travel consultant's name

Date insurance paid for Date travel arrangements booked

Date departed Date returned

your health

Did you apply and pay for any Existing Medical Condition cover?
Yes No

If **Yes**, please provide the reference number below

other insurance/claims

Can you claim/have you claimed from any other source? (e.g. airline, transport provider, travel agent, third party etc.) Yes No

Details Amount received
 £

Do you have private health insurance? Yes No

Name of fund Policy number

Can you claim from them for this event? Yes No

If **Yes**, include your statement of benefits giving evidence of the amount received.

Have you made a travel insurance claim in the past? Yes No

If **Yes**, please give details

Date Company name

Amount claimed Type of claim
£

Certain credit cards may provide basic travel insurance cover which may also cover your loss. Do you have credit card/s? Yes No

If **Yes**, with which provider and which card type/s?

Provider (e.g. Barclays) Type (e.g. Gold Visa)

Did you purchase part or all of your travel on the card/s? Yes No

settlement of your claim

We will deposit the amount payable directly to the bank account you nominate.
NOTE: We cannot deposit to credit card or non-UK accounts.

Sort code (must be 6 digits) Account number (must be 8 digits)

Name of account holder Name of bank

warning

To avoid passing the cost of dishonest and fraudulent claims on to you, our honest policy holder, we are strongly committed to investigating claims. All cases of fraud will be reported to the Police and can also result in civil action by the insurers.

your declaration

I/we declare that all statements and particulars stated on this form and all documents submitted are true and correct. I/we have not withheld any material information connected with this claim that will inhibit the insurers ability to make a fair and reasonable assessment of my claim.

I/we assign to insurers all rights of recovery/salvage against any person or organisation and will cooperate to secure such rights.

I/we acknowledge that the underwriter or it's agents may give to and obtain from any other insurer or insurance reference bureau, information relating to this or any other insurance held by me/us, or any claim made by me/us and I also authorise any other insurer to provide information relating to this or any claim made by me.

Your name Your name

Signature Signature

Date Date

please tell us what happened in as much detail as possible

Date of incident Time am/pm Country Location

Explanation (Please attach a letter if more space is required)

Person whose state of health caused the claim

Surname First name Has the illness/injury occurred before? Yes No

Date of birth Relationship of that person to you Date and time admitted Date and time discharged

Has the illness/injury occurred before? Yes No Did you contact the 24 hour Emergency Assistance company? Yes No

If **Yes**, please give details

If **No**, why not?

medical and dental expenses - please list each bill/receipt separately

Date	Provider's name	Description/Reason	Amount	Currency	Paid Yes/No	Office use only

Did you pay the policy excess directly to the provider? Yes No If **Yes**, please attach the original receipt

Are you expecting to receive further bills for this event? Yes No If **Yes**, please give details below

medical authority

To be completed by the person whose state of health caused the claim or the Executor of the Estate, if applicable

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for the condition/s which result in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original.

Surname First name Date of birth Signature

Name of usual doctor in the UK Doctor's phone Doctor's fax

Doctor's address (include postcode)

medical certificate

To be obtained at the claimant's expense from the patient's usual doctor in all cases of Amendment or Cancellation Costs resulting from accident, illness or death

IMPORTANT: The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries. The claimant is responsible for any fee imposed. **** PLEASE USE BLOCK LETTERS ****

1. Full name of patient

Date of birth

2. Patient's relationship to claimant

3. Are you the patient's usual GP? Yes No

If **Yes**, for how long?

If **No**, please provide full details of the patient's usual GP

4. a Please give a precise diagnosis of the illness, injury or cause of death. If an injury, how was it sustained?

b If due to a pregnancy, on what date was the pregnancy confirmed?

c How many weeks pregnant was the person on this date?

d Was the conception medically assisted? Yes No

e Have there been complications with this or any other pregnancy? Yes No

f Expected delivery date

5. Date of onset of illness, injury or date of death

6. Date on which you were first consulted in relation to this

7. Date referred to specialist

8. Date tests prescribed and carried out

9. Date results advised to patient

10. Date there was a deterioration

11. Name and address of specialist/surgeon

12. Have you or anyone else previously treated the patient in respect of the same/similar/related illness or injury as described in question 4? Yes No

If **Yes**, state if same illness or injury, or specify similar/related illness or injury (please give full details including dates)

13. Was the patient advised to continue this treatment and/or medication

■ Until departure on this journey Yes No

■ Whilst on this journey Yes No

14. Was the patient hospitalised? Yes No

Yes No

If **Yes**, advise admission date

15. a Please provide details of the patient's health at the time when the insurance was issued and the likelihood of the patient's health causing a claim (see claimant for exact date)

b Was the patient being treated for the condition which caused the cancellation or curtailment at or prior to the date the insurance was issued? Yes No

Yes No

16. Was the patient on a waiting list for admission to hospital? Yes No

Yes No

If **Yes**, please state

Date they were on the waiting list

Date of admission

17. Was it reasonable of the claimant to continue with travel plans considering the answer to the other questions? Yes No

Yes No

18. Are you prepared to certify that solely due to the condition described in question 4, the claimant/s was/were required to cancel or curtail the travel arrangements? Yes No

Yes No

THE FOLLOWING QUESTIONS ONLY APPLY IF THE PATIENT WAS IN THE TRAVELLING PARTY

19. Date it became apparent the patient would not be able to travel (if applicable)

20. How long was or will the patient be prevented from travelling?

from to

21. Had the patient planned to travel against your prior advice? Yes No

If **Yes**, please give details

22. Did the patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment? Yes No

Yes No

If **Yes**, please give details

I certify that the statements contained in this Medical Certificate are true and correct.

Doctor's name

Doctor's signature

Date

Qualification

Phone

Fax

Address

Company stamp