

Travel Claim Form



Medical Expenses/ Curtailment and Repatriation

Guidance Notes – Medical Expenses, Curtailment and Repatriation

Most delays in settling claims arise because claim forms are not fully completed or requested documents are not sent to us. We would therefore ask you to answer all questions (dashes and spaces cannot be accepted).

You should read and sign the declaration and refer to the guidance notes overleaf for details of what we require.

We are committed to ensuring our customers get the right help when they need it. If there are any specific circumstances or requirements that you think we should know about, such as a disability, financial hardship, bereavement — or anything else, then please let us know.

Please return the completed claim form to your Insurance Agent. Thank you for your co-operation.

Please note that if you are unable to supply any of the evidence we request, you should include a separate covering note explaining this. This will enable us to deal with your claim promptly.

ALL CLAIMS We require the following documentation

- The Tour Operator’s or Service Providers Booking Invoices and travel tickets confirming the Period of Travel.
- A copy of your certificate of Insurance.
- Except in the case of minor illness or injury, the medical certificate on the back page of this claim form will be required. This should be completed by the usual medical practitioner of the ill/injured/deceased person. Where this is not completed, we reserve the right to require its completion at a later stage.
- If the claim arises from the death of any person, a certified copy of the death certificate should be provided.

Medical and Repatriation Expenses

- Invoices from service providers showing charges made against you, together with receipts you received confirming payment.
- If you returned earlier or later than planned, you should submit the medical certificate issued by the doctor who treated you abroad showing that this was necessary on medical grounds.
- If you received treatment in an EEC Country, you should submit a completed EHIC form which can be obtained from your local Post Office. You must also complete and sign the disclaimer section on the claim form

Curtailment

- The medical certificate issued by the doctor who treated you abroad, showing the medical need to return home earlier than planned.

CHECK LIST

The following is provided for your convenience to enable you to check that you have sent the appropriate information to us.

Booking Invoice	<input type="checkbox"/>	Claim Form	<input type="checkbox"/>
Medical Certificate obtained abroad	<input type="checkbox"/>	Death Certificate	<input type="checkbox"/>
Copy of Certificate of Insurance	<input type="checkbox"/>	Travel Tickets	<input type="checkbox"/>
Doctor’s Report completed	<input type="checkbox"/>	Expenses Receipts	<input type="checkbox"/>
EHIC	<input type="checkbox"/>		
Date claim form posted	<input type="text"/>		

Policy Number Date Issued

Insurance Issued by

(Agent's name and address & Postcode)

Policyholder's Name

Insured's Surname Initial Title (Mr/Mrs/Miss/Ms, etc) Age

Address Postcode

Occupation

Home Tel. No. (inc. STD) Work Tel. No. (inc. STD)

Purpose of trip e.g. Business/Pleasure

Date Trip booked Date of Departure Date of Return

Name of injured/ill person Date of Birth

Nature of injuries/illness Date of Accident/Commencement of Illness

Place of accident/illness (country) Resort

Circumstances of Accident/Illness

If Hospitalised, Name and Address of Hospital

Date Admitted Time hrs Date Discharged Time hrs

How were you conveyed to hospital? (delete as necessary) HELICOPTER/AMBULANCE/TAXI/OTHER(explain)

Did you return home earlier than planned? Yes ☐ No ☐ If Yes, on what date?

Are you claiming for any unused accommodation or travel? Yes ☐ No ☐ If Yes, please give details

Did you contact the assistance company? Yes ☐ No ☐ If Yes, please confirm date

Have you made any previous claims under this or any other insurance? Yes ☐ No ☐

If Yes, please give details

IMPORTANT NOTICE No settlement can be made if invoice documents are not provided for our inspection. (N.B. Photocopies are NOT acceptable). If invoices are unpaid and require direct settlement with the service provider, please give name(s) and address(es) of payee(s) below.

Date expense incurred	Description of Invoice (e.g. Doctors Fee, Taxi, etc.)	Full Name/Address of Payee if direct settlement required	Was a GHIC or EHIC presented? Yes/No	Amount of Bill and Currency	Paid by you? Yes/No

DISCLAIMER

The following should be completed and signed by those who incurred medical expenses in an EEC country

I hereby consent to Insurers seeking reimbursement of medical expenses paid by them out of medical treatment received in

(Country) from an illness/injury which commenced on (date)

Signed Date

PLEASE NOTE THAT ALL CLAIMANTS MUST SIGN THE DECLARATION OVERLEAF

Do you have Private Health Insurance?
If Yes, please provide Insurance Company

Yes ☐ No ☐

Name

Address

Postcode

Policy No.

DECLARATION

I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form is to the best of my knowledge and belief, true in every respect and that I have declared and not claimed amounts refunded to me or claimed from any other source. **You must read the declaration before signing**

Signed

Date

DOCTOR'S REPORT

(To be completed by the usual medical practitioner of the person causing the claim)

Name of person to whom this report refers (the patient)

Are you the patient's usual practitioner?

Yes ☐ No ☐

How long have you acted in this capacity for? Years

What is the precise nature of the illness/injury that caused the repatriation, curtailment or medical expenses to be incurred?

When were you first consulted about this condition?

Has the patient suffered from the same or a similar condition in the past?

Yes ☐ No ☐

If Yes, please provide date(s) of previous treatment(s)

Has the patient been included on a waiting list for in-patient treatment?

Yes ☐ No ☐

If Yes, please advise date that they were first put on the list

DECLARATION

I have examined the patient and/or their medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signature

PRACTICE STAMP

Name

Qualification

Date

IMPORTANT NOTICE TO ALL CLAIMANTS

In the event that your claim is successful, we shall most likely issue payment by BACS transfer directly into your bank account, as this is both a faster and more secure form of payment.

Can you please complete the boxes with your bank account number, bank sort code, bank name and bank address ensuring our claims reference is quoted.

Arch utilise an encrypted email system, but if your email system is not encrypted, we cannot guarantee the security of your communication and you may wish to consider alternative methods of submitting these details.

Please detach the final page if details regarding your claim need to be completed by your vet, doctor or other such professional, due to the sensitive data contained.

Name of Bank	
Branch	
Sort Code	
Account No.	
Account Name	
Claims Reference	
Signature	Date