Travel Claims Form

STEP 1 – CLAIM FORM COMPLETION REQUIREMENTS

Please complete this form and sign. Please provide further information on a separate sheet if necessary. Failure to disclose all material information and/or misrepresentation could result in your insurance being declared void by the insurer and a claim being rejected. When complete, please click "SUBMIT" to send this form via email, or fax it to 295-8647, or return it by hand to BF&M's Headquarters in the Insurance Building on Pitts Bay Road, Pembroke.

STEP 2 – CLAIMANT DETAILS

Policy and Claimant Details

All questions in this section must be answered

NAME OF POLICY HOLDER(S)			NAME OF CLAIMANT (Mr/Mrs/Miss/Ms)		
POLICY NUMBER			DATE OF BIRTH		
			DAY	MONTH	YEAR
ADDRESS			POSTCODE		
PHONE (HOME)	PHONE (WORK)		PHONE (CELL)		
EMAIL ADDRESS					
TRAVEL AGENT IF USED			DATE BOOKING TRAVEL ARRANGEMENTS		
			DAY	MONTH	YEAR
DATE OF DEPARTURE			DATE OF RETURN		
DAY	MONTH	YEAR	DAY	MONTH	YEAR

Provide your bank details below for a direct deposit to your bank account. Please note we cannot deposit into a credit card account. Payment will be less any applicable excess.

NAME OF BANK
ACCOUNT HOLDER
ACCOUNT NUMBER

A. Travel Arrangements

1. Did you use a credit card to purchase your travel (eg. Flights, accommodation, tours)? Yes ☐ No ☐
2. If ***Yes***, please complete the following: Name on Credit Card _____ Name of Financial Institution _____

Card Type: Visa ☐ Mastercard ☐ Amex ☐ **Card Level:** Gold ☐ Platinum ☐ Other _____

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STEP 3 – CLAIM INFORMATION

Please tick the applicable box(s) relating to your claim type and answer the appropriate Section

- ☐ A. Personal Accident
- ☐ B. Cancellation
- ☐ C. Medical & Emergency Travel Expenses
- ☐ D. Personal Property
- ☐ E. Delayed Luggage Expenses Claim

Please answer all questions relating to what is being claimed, otherwise we will be unable to process your claim.

A. Personal Accident

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance
2. Medical/Hospital/Dental Report detailing Treatment and Diagnosis
3. Itemised accounts giving a breakdown and description of costs claimed, together with receipts if any accounts have been paid by you
4. Completed Medical Certificate

Failure to provide these documents may result in delays in processing your claim.

TYPE OF INJURY OR SICKNESS	DATE OF ACCIDENT OR COMMENCEMENT OF SICKNESS		
	DAY	MONTH	YEAR

IF INJURY – GIVE FULL DETAILS OF ACCIDENT

DATE OF FIRST MEDICAL/DENTAL CONSULTATION			NAME OF DOCTOR, DENTIST AND/OR HOSPITAL
DAY	MONTH	YEAR	

DETAILS OF OTHER TREATMENT BY DOCTOR, DENTIST AND/OR HOSPITAL

HOSPITAL ADMITTED DATE			HOSPITAL DISCHARGED DATE			TIME	
DAY	MONTH	YEAR	DAY	MONTH	YEAR	A.M.	P.M.

HAVE YOU EVER SUFFERED FROM THE SAME OR SIMILAR INJURY OR SICKNESS IN THE PAST?	HEALTH INSURER

IF YES, GIVE DETAILS INCLUDING DATES, NAMES AND ADDRESSES OF TREATING PHYSICIANS

NAME AND ADDRESS OF USUAL FAMILY DOCTOR

Please list each receipt/bill separately in the table below.

NAME OF DOCTOR/DENTIST/PHARMACY/ HOSPITAL OR PROVIDER	TREATMENT PERFORMED	DATE OF TREATMENT			AMOUNT CHARGED (STATE CURRENCY)
e.g. Doctor	e.g. Consultation, Surgery	e.g.D/M/Y			e.g. EUR 100
		DAY	MONTH	YEAR	
		DAY	MONTH	YEAR	
		DAY	MONTH	YEAR	

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B. Cancellation

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of original itinerary
2. Terms and Conditions issued by Travel Agent and/or Transport, Tour or Accommodation Provider
3. Letter from Travel Agent or, where travel was not arranged through a Travel Agent, a letter from the relevant organization through whom travel was booked, confirming payments made, refunds given and any amounts you are out of pocket
4. Proof of payment for trip (ie. Receipts, credit card/bank statements showing payments made)
5. If travel was cancelled due to Medical Reasons/Death – completed Medical Certificate (see last page of claim form) and copy of Death Certificate (if applicable)

Failure to provide this documentation may result in delays in processing your claim.

WHAT WAS THE REASON YOU COULD NOT COMMENCE OR COMPLETE YOUR PROPOSED JOURNEY?

Was your Journey cancelled as a result of Injury/Sickness to yourself? Yes ☐ No ☐

Was your Journey cancelled as a result of Injury/Sickness to any other person? Yes ☐ No ☐

IF YES, PLEASE PROVIDE FULL NAME					
RELATIONSHIP			**DATE OF BIRTH**		
			DAY	MONTH	YEAR
ADDRESS					
NATURE OF INJURY/SICKNESS					
DATE YOUR JOURNEY WAS BOOKED			**DATE YOUR JOURNEY WAS CANCELLED**		
DAY	MONTH	YEAR	DAY	MONTH	YEAR

Details of Journey

DATE			DESCRIPTION OF BOOKING	SUPPLIER	AMOUNT PAID	REFUND RECEIVED	AMOUNT CLAIMED
DAY	MONTH	YEAR					
DAY	MONTH	YEAR					
DAY	MONTH	YEAR					
DAY	MONTH	YEAR					
DAY	MONTH	YEAR					

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C. Medical & Emergency Travel Expenses

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance
2. Copy of original Itinerary
3. Receipts, bank/credit card statements showing amounts paid by your for original Itinerary
4. Proof of payment for additional expenses claimed (ie. tax invoices, receipts, credit card/bank statements showing payments made)
5. If the additional expenses were incurred due to the unfortunate event of a death – a copy of the Death Certificate

Failure to provide these documents may result in delays in processing your claim.

PLEASE STATE THE REASON/EVENT THAT CAUSED THE ADDITIONAL EXPENSES BEING INCURRED

WHAT WAS THE UNEXPECTED EXPENSE INCURRED?

Please list each receipt/bill separately in the table below.

DATE			DESCRIPTION OF BOOKING	AMOUNT	DATE OF ORIGINAL PLAN			DESCRIPTION OF ORIGINAL COST	AMOUNT
			E.G. HOTEL EXPENSE	CURRENCY/AMOUNT				FLIGHT	CURRENCY/AMOUNT
DAY	MONTH	YEAR			DAY	MONTH	YEAR		
DAY	MONTH	YEAR			DAY	MONTH	YEAR		
DAY	MONTH	YEAR			DAY	MONTH	YEAR		
DAY	MONTH	YEAR			DAY	MONTH	YEAR		
DAY	MONTH	YEAR			DAY	MONTH	YEAR		

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D. Personal Property

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance
2. Proof of ownership of the items claimed (ie. Duty, invoices, receipts, or credit card/bank statements proving purchase of the item/s)
3. Report made to the Transport Provider/Police/Hotel or other appropriate Authority
4. Any photos showing Proof of Ownership

Failure to provide these documents may result in delays in processing your claim.

GIVE FULL DETAILS OF HOW LOSSES, DAMAGE OR THEFT OCCURRED: (DETAIL EACH EVENT)					
DATE LOSS/DAMAGE OCCURRED			**TIME AM/PM**		**LOCATION/COUNTRY**
DAY	MONTH	YEAR	A.M.	P.M.	
DATE LOSS/DAMAGE REPORTED			**TIME AM/PM**		**LOCATION/COUNTRY**
DAY	MONTH	YEAR	A.M.	P.M.	
LOSS/DAMAGE REPORTED TO – (POLICE, AIRLINE OR OTHER AUTHORITY) NAME					
WERE ITEMS LOST, DAMAGED BY CARRIER? (E.G. AIRLINE)					**IF YES, CARRIER NAME**

Have you made a claim or complaint against any Carrier/Airline or other Authority or against any individual responsible for the loss or damage to your property? If YES, please provide details in the table below and attach copies of correspondence. If No, you should proceed to claim with your Carrier/Airline before submitting your claim

ARE ANY OF THE ITEMS COVERED BY OTHER INSURANCE?	**IF YES – WHICH COMPANY LOCATION/COUNTRY**
Yes ☐ No ☐	
POLICY NUMBER	**WERE ALL THE MISSING ARTICLES OWNED BY YOU?**
	Yes ☐ No ☐
IF NOT, GIVE DETAILS	

FULL DETAILS OF ARTICLES CLAIMED	STORE FROM WHERE ITEM WAS ORIGINAL PURCHASED	ORIGINAL DATE OF PURCHASE			ORIGINAL PURCHASE PRICE	AMOUNT CLAIMED (USD)	PROOF OF PURCHASE ATTACHED?
		DAY	MONTH	YEAR			Yes ☐ No ☐
		DAY	MONTH	YEAR			Yes ☐ No ☐
		DAY	MONTH	YEAR			Yes ☐ No ☐
		DAY	MONTH	YEAR			Yes ☐ No ☐

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E. Delayed Luggage Expenses Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance
2. Itemised receipts for the purchase of Essential Items claimed by you
3. Property Delay. Report from the Carrier (ie. bus line, airline, shipping line or rail authority) and confirmation of any compensation paid to you
4. Ticket and Baggage Tags from the Carrier who caused your luggage to be delayed

Failure to provide these documents may result in delays in processing your claim.

NAME OF CARRIER WHO DELAYED YOUR LUGGAGE				
YOUR ARRIVAL DATE			YOUR ARRIVAL TIME AM/PM	
DAY	MONTH	YEAR	A.M.	P.M.
DATE THAT YOUR LUGGAGE WAS RETURNED TO YOU			TIME OF RETURN AM/PM	
DAY	MONTH	YEAR	A.M.	P.M.
WHAT COMPENSATION WAS RECEIVED FROM THE CARRIER				

Please complete the below schedule in full. Claims will be converted using the currency rate applicable at the date and time the expenses were incurred.

DESCRIPTION OF ESSENTIAL ITEMS PURCHASED	DATE OF PURCHASE			PRICE PAID	STORE WHERE ITEM WAS PURCHASED	RECEIPT ATTACHED
E.G. TOOTHBRUSH					E.G. WALMART	
	DAY	MONTH	YEAR			Yes ☐ No ☐
	DAY	MONTH	YEAR			Yes ☐ No ☐
	DAY	MONTH	YEAR			Yes ☐ No ☐

Please review all details carefully before submitting.
Click SUBMIT to send via email to submitclaim@bfm.bm.

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MEDICAL CERTIFICATE

To be completed by the patient's usual Doctor/Dentist (at the claimant's expense) in all cases of cancellation and medical claims resulting from accident, sickness or death.

NAME OF PERSON TO WHOM THIS CERTIFICATE APPLIES (I.E. THE PERSON WHOSE STATE OF HEALTH CAUSED THE CLAIM):	DATE OF BIRTH		
	DAY	MONTH	YEAR
ADDRESS:	**POSTCODE**		

Instructions to the Medical Professional:

Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Travel Insurance claim.

1. (a) Are you the patient's usual medical practitioner? Yes ☐ No ☐ If Yes, for how long? _____

(b) If No, do you have access to their medical records? Yes ☐ No ☐

The claimant must indicate (by ticking the relevant box) which is applicable, question 2 or 3.

2. Alteration to/cancellation of travel arrangements prior to travel.

(a) Did you recommend that travel be cancelled or postponed due to the patient's state of health? Yes ☐ No ☐

(b) On what date did you make this recommendation? DAY MONTH YEAR

(c) Please give precise details of the nature of the sickness or injury which gave rise to this recommendation (including the final diagnosis)

(d) Did you fully explain the risk of travelling with this medical condition? Yes ☐ No ☐

(e) On what date did the patient first become aware of their symptoms? DAY MONTH YEAR

(f) Please describe the symptoms advised by the patient.

(g) On what date were you first made aware of the condition, or change in the condition? DAY MONTH YEAR

(h) Has the patient previously been investigated, diagnosed or treated in respect to the same/similar/related sickness or injury? Yes ☐ No ☐

If Yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

(i) Did the patient make the travel arrangements against your advice (or the advice of another medical practitioner)? Yes ☐ No ☐

OR

3. Treatment costs/additional expenses incurred during travel.

(a) What do you understand to be the sickness or injury which resulted in the need to seek medical care/interrupt the patient's travel plans?

(b) Has the patient previously been investigated, diagnosed or treated in respect to the same/similar/related sickness or injury? Yes ☐ No ☐

If Yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

(c) Was there any indication that medical care may be required on the journey? _____

(d) Was the patient non-compliant with medical advice whilst on the journey? Yes ☐ No ☐

(e) Did the patient travel against your advice (or the advice of another medical professional)? Yes ☐ No ☐

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

Doctor's Signature _____ Date DAY / MONTH / YEAR Doctor's Stamp

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