M EMERGENCY MEDICAL EXPENSES, HOSPITAL INCONVENIENCE BENEFIT

travel claims facilities

Claims Dept
PO Box 420
Hadlow
Kent
TN9 9DE

Tel: 0845 370 7187
Fax: 0870 620 5001
Web: www.tif-plc.co.uk

Dear Customer,

In order that we can process your claim quickly, please complete all relevant sections of the claim form, giving as much detail as you can and **return it to us at the above address,** together with the following **ORIGINAL** documentation. Please note that in the interest of protecting ourselves from fraud we are unable to accept photocopied receipts or invoices.

We recommend that you keep your own copy of all documents forwarded to us.

To help you enclose the correct paperwork to support your claim we have put together a checklist. Please ensure you read this carefully as failure to supply the correct documents may result in your claim form being returned to you.

CHECKLIST OF DOCUMENTS REQUIRED

ALL CLAIMS

- ☐ DOCUMENTATION SHOWING YOUR TRAVEL DATES (booking invoice)
- ☐ PROOF OF INSURANCE i.e. certificate/schedule or confirmation email. As claims handlers we do not hold this information.
- ☐ ALL MEDICAL OR PHARMACUETICAL BILLS / RECEIPTS
- ☐ PHOTOCOPY OF PRIVATE HEALTH INSURANCE / VHI SCHEDULE (VHI Healthcare)
- ☐ YOUR EHIC CARD IF TRAVEL WAS TO AN EUROPEAN UNION MEMBER

IF YOU HAVE DISCLOSED ANY PRE-EXISTING MEDICAL CONDITIONS TO YOUR INSURANCE COMPANY

- ☐ ENDORSEMENT CONFIRMING THAT YOU HAVE PURCHASED THIS ADDITIONAL COVER
- ☐ PROOF THAT YOU HAVE PAID ANY ADDITIONAL PREMIUM REQUIRED

IF YOU WERE CONFINED TO BED ON THE ADVICE OF A DOCTOR OR RETURNED HOME EARLY ON MEDICAL RECOMMENDATION

- ☐ A MEDICAL CERTIFICATE FROM THE ATTENDING DOCTOR CONFIRMING THE NEED TO BE CONFINED TO BED OR THE NECESSITY TO CUT SHORT YOUR TRIP

IF YOU WERE ADMITTED TO HOSPITAL AS AN INPATIENT

- ☐ COPIES OF ANY MEDICAL REPORTS AVAILABLE
- ☐ CONFIRMATIOM OF HOSPITAL IMPATIENT ADMISSION AND DISCHARGE DATES AND TIMES

You should note that all the information provided to us on this form will be stored electronically in accordance with The Data Protection Act and shared with the Insurance Industry Fraud Prevention Unit. If you make a fraudulent or intentionally exaggerated claim this will invalidate your claim and we will pursue a recovery through the civil courts in all cases.

We do understand that it may take time to collect all the documentation required but please try to submit your claim as soon as possible after the event.

Yours faithfully

Travel Claims Facilities

CLAIM FOR EMERGENCY MEDICAL EXPENSES – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

TO BE COMPLETED BY THE CLAIMANT

Title:

First Name: **Surname:**

Address:

Post Code:

Telephone: **Date of Birth:** DD / MM / YY

Email:

National Insurance Number: two letters, six numbers and a final letter

DETAILS OF THE INSURANCE POLICY

Where / who did buy your insurance from:

Policy name: **Date Policy Issued:** DD / MM / YY

Policy Found on Schedule, Certificate, or Booking Invoice **Master Policy Number:** Found on policy wording (ABCDE400…)

Destination: i.e. Europe / Worldwide

Medical Screening reference number:

DETAILS OF TRIP

Travel Agent / Tour Operator:

Date Trip Booked: DD / MM / YY **Date final balance paid:** DD / MM / YY

Method of payment (cash, cheque, debit card, credit card)**:**

Trip Dates From: DD / MM / YY **To:** DD / MM / YY

MEDICAL DETAILS OF CLAIM

Please give details of the circumstances leading up to your accident/illness and full details of the injury/sickness suffered:

When did the incident occur: DD / MM / YY **Where:** **Time:** HH : MM

Where were you treated:

What was the name of the doctor who treated you:

Was this facility either: State: Private:

Did you use an EHIC card or take advantage of a reciprocal agreement to obtain free treatment: Yes: No:

Did you contact our appointed emergency assistance services (EMS) for advice: Yes: No:

Date of your first call: DD / MM / YY **Time:** HH : MM **Reference No.**

Name of person handling your case:

CLAIM FOR EMERGENCY MEDICAL EXPENSES – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

MEDICAL DETAILS OF CLAIM

Was the treatment you received related to any previous treatment you have had at home: Yes: No:

If so, please give details:

If your treatment was necessitated by an accident, was anyone else involved and could they be held responsible for what happened: Yes: No:

If yes, please give names and addresses and if possible telephone numbers, of these people and any witnesses, on a separate sheet of paper, along with a reason why you hold them responsible.

Do you have any private health insurance or VHI cover: Yes: No:

If yes, please name the scheme and give your membership number:

Have you ever suffered from the following medical conditions? If yes, please provide details and dates. If you require more space, please continue overleaf or on a separate sheet.

Any cardiac or circulatory conditions?	
Any respiratory conditions?	
Any type of diabetes?	
Hypertension?	
Stroke?	
Any type of Cancer?	

ITEMISE YOUR CLAIM

On this page please give details as accurately as possible of the bills either to be paid by your insurance company on your behalf or those which you have already paid and are seeking a refund for. If you do not yet know the amount, please list the name of the provider who will send an account directly to us as this will help us match bills to your claim when they arrive. We will need original receipts for all expenses claimed including that for any policy excess you paid directly to the provider. If you paid by debit or credit card, please enclose a statement showing the rate of exchange applied.

TYPE OF EXPENSE Examples below:	NAME OF SERVICE PROVIDER	AMOUNT IN LOCAL CURRENCY	PAID / NOT PAID	METHOD OF PAYMENT
Ambulance, Hospital	Orlando Ambulance Co.	$350.00 US Dollars	P / NP	Visa Debit

CLAIM FOR EMERGENCY MEDICAL EXPENSES – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

PLEASE ADVISE THE NAME OF THE PERSON TO WHOM THE SETTLEMENT CHEQUE SHOULD BE MADE OUT TO:

Title: **First Name:** Please print **Surname:** Please print

Were you able to return on your original booked flight: **Yes:** **No:**

If No, have you enclosed your unused tickets: **Yes:** **No:**

If you have received a refund, please advise the amount: £

If you are claiming Hospital Benefit, please supply the following information:

HOSPITAL BENEFIT

Were you admitted to a state hospital as an inpatient or were you confined to your cabin on the advice of a registered doctor: **Yes:** **No:**

Please give details of the treating hospital/s:

Name:

Address: (Please include Country)

Confined from: DD / MM / YY **Time:** HH / MM

Confined to: DD / MM / YY **Time:** HH / MM

Due to your incapacity, did you miss any trips or excursions that you paid for before you left your home country? If yes, please advise the following details:

Date of excursion:	Description:	Cost:
DD / MM / YY		£
DD / MM / YY		£
DD / MM / YY		£
DD / MM / YY		£
DD / MM / YY		£
	Total:	£

CLAIM DECLARATION:

- ✓ I/We declare that all the details provided above are true and accurate to best of my knowledge.
- ✓ I/We give consent for Travel Claims Facilities to seek recovery of monies paid where other insurers cover the same risk, or from third parties who may be held liable.
- ✓ I/We understand that details of this claim may be passed to the insurance industries central claim register
- ✓ I/We understand that if a claim is found to be fraudulent of exaggerated that this will invalidate the whole claim and Travel Claims Facilities may seek to recover any costs through the civil courts.

Once you have read and agreed to the above declarations, please sign and date below.

Signed: **Dated:** DD / MM / YY

Please print name:

In order for us to obtain any further medical reports, would you please be kind enough to complete and sign the details below and return this form to us, which will allow us to contact your / the patient's General Practitioner for more detailed information which will assist in the assessment of your claim. We will pay any costs incurred in relation to additional information being requested by us.

ACCESS TO MEDICAL REPORTS ACT 1988

This policy is insured by Union Reiseversicherung UK (URV), if they or any of their agents require information from your doctor in respect of your insurance you have certain rights under the Access to Medical Reports Act 1988: -

- Your consent* is required before URV or anyone acting as their agent can apply for a report and you may see the report before it is supplied to URV or their agents, or at any time during the six months after that.
- If you disagree with the contents of the report or consider it to be misleading you may ask your doctor to amend it. If the doctor disagrees you may add your own written comments. The doctor may withhold all or part of the report from you if he/she thinks that this would be in your best interests, or that of others. . Alternatively you can refuse consent*.
- At no time will the report be sent to URV or anyone acting as their agent without your consent.

*You can refuse to give your consent however this may mean we are unable to deal with your claim

Charges made by the doctor for providing such a report to URV are for your own account, as they are not covered by this policy.

DETAILS OF THE PATIENTS/YOUR USUAL GENERAL PRACTIONER

Patient Name:

Name of General Practitioner:

Surgery Address:

Post Code:

Telephone Number:

Name of Hospital admitted to (if applicable):

Consultant Name:

DECLARATION

I consent to URV or anyone acting as their agent, seeking medical information from any doctor who has any at any time attended me concerning anything which affects my/the patient's physical and/or medical health. I authorise the giving of such information during and after my lifetime.

I have been informed of and understand my rights under **Access to Medical Reports Act 1988** (see above).

I do / do not wish to see any report before it is sent: I do: **I do not:**

Patients name: **Date of Birth:** DD / MM / YY

Patients address:

Post code:

Signature of patient or **Signature of next of kin** **Date:** DD / MM / YY

Please print name:

If next of kin, please advise your relationship to the patient:

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SETTLEMENT BY BACS

For your convenience and to offer an efficient smoother service, we would like to pay any claim settlement due directly into your bank account. Please provide your details on this form, remembering to sign and date below.

If you do not wish to provide your bank details, any settlement due on your claim will be issued by cheque and may take a little longer to process.

YOUR DETAILS

Name of Claimant

BANK ACCOUNT DETAILS

Name of Payee

This should be the same as held on the bank account

Bank Name

Bank Address

Bank Address

Bank Address

Country **Post Code**

Bank Account number

Sort Code - -

If your bank account is held abroad, please also enter the following details:

IBAN / BIC number

Swift code

Signed **Dated**

We do not accept liability for any errors due to the incorrect bank details being provided by you.