Expatriate Healthcare's TravelCare Claim Form (v.20161007)

To help us process your claim quickly, please follow these guidelines:

- Complete a separate claim form for each claim and for each insured person.
- If you are submitting a claim following an accident or injury, please complete in full Sections A, B & H.
- If you are submitting a claim for a non-medical incident or personal luggage loss, please complete Sections A, (E - F as appropriate) & H.
- If you are submitting a Personal Accident claim, please complete Sections A, G & H.
- Please send this fully completed form to the Expatriate Healthcare**,** with ALL original bills relating to the claim, plus proof of travel (e.g., email confirmations of trip, booking invoices, tickets.)

PLEASE NOTE: All submissions MUST be received within 90 DAYS of the date of the loss or commencement of treatment.

A. DETAILS OF INSURED

POLICY HOLDER DETAILS		
Name (Last, First, MI):	Policy Number:	
Address:		
Postal Code / Zip:	Phone Number:	
E-mail:	Fax:	
CLAIMANT DETAILS (if different from above)		
Name (Last, First, MI):		
Address:		
Postal Code/Zip:	Phone Number:	
Occupation:		
Was journey:	☐ Holiday	☐ Business
Dates of journey:	From:	To:
Is the claim the result of an accident?	☐ Yes	☐ No
PLEASE LIST DOCUMENTS ENCLOSED:		

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Sections B-F of this form should be completed by the Insured Person who is the Claimant or (in the case of a minor) the parent or guardian.

B. MEDICAL EXPENSES & HOSPITAL BENEFIT – Sections 3 & 4 of the Policy		
Nature of illness/injury:		
Date and time of illness/injury:		
Please confirm where the illness/injury took place:		
Please provide a detailed description of how the injury occurred:		
Name and address of doctor(s) and/or hospital(s) from which treatment was received:		
Details of claimant's personal family physician / doctor:		
Address:	Phone Number:	
	Fax Number:	
	Email:	
If treatment was given in hospital as an inpatient please confirm the dates:		
Was the Emergency Assistance Company contacted: ☐ Yes ☐ No If no, please state the reason why not:		
Was the insured Person pregnant: ☐ Yes ☐ No If yes, how many weeks?		
If the Insured Person has suffered illness, has he/she suffered from this before: ☐ Yes ☐ No If yes, please provide details:		
Does the Insured Person have Private Medical Insurance: ☐ Yes ☐ No If so, please provide the insurance carrier details including name, address and policy number:		
FOR EU CITIZENS ONLY		
Was an EHIC (European Health Insurance Card) taken on the trip: ☐ Yes ☐ No		
Was this presented to the hospital/doctor? ☐ Yes ☐ No		
Please attach all medical invoices and receipts which are relevant to your claim. A delay in submitting this documentation could result in a delay in the settlement of your claim.		

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C. CANCELLATION OR CURTAILMENT – Section 1 of the Policy		
Date the journey was booked:		
When was the journey cancelled or curtailed:		
Please provide a detailed explanation of why the journey was cancelled / curtailed:		
If the cancellation was not due to the person travelling please confirm the name of the person who caused the trip to be cancelled and his/her relationship to the person(s) travelling:		
If the journey was cancelled due to injury/illness of the person travelling we will require written confirmation from the General Practitioner that the Insured Person was unfit to travel. If the journey was cancelled due to the injury/illness of a third party, we will require written confirmation third party's General Practitioner confirming the injury/illness. Please also provide documentation in support of the cancellation of the trip for any other factor not described above. Please provide the original booking invoice and the cancellation invoice showing the charges incurred.		
If the journey was curtailed, was the Emergency Assistance Company contacted?	☐ Yes	☐ No
Were any additional expenses incurred? If yes, please provide details below and send all invoices/receipts with this claim form:	☐ Yes	☐ No
Please confirm to whom reimbursement should be made payable:		

D. TRAVEL DELAY / MISSED DEPARTURE – Sections 8 & 9 of the Policy	
Reason for delayed/missed departure:	
TRAVEL DELAY	
Schedule date and time of departure:	
Flight/Ferry/Other Transport Number/Ref:	
Actual date and time of departure:	
Flight/Ferry/Other Transport Number/Ref:	
Number of hours delayed:	
Airline/Ferry/Other Transport Company Name:	
MISSED DEPARTURE	
Point of departure:	Point of Missed Connection:
Method of transport being used to arrive at departure point:	
Please confirm how you recommenced trip:	
Amount claimed:	

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E. BAGGAGE, PERSONAL EFFECTS, MONEY & DOCUMENTS – Sections 5 & 6 of the Policy	
Date of loss or damage:	Time:
Please provide a detailed description of how the loss/damage occurred, including the location:	
Please confirm when the loss/damage was reported and to which authority (e.g., police/airline/tour operator/hotel, etc.), including complete address and reference:	
If the loss relates to travellers cheques / cheques /cash /credit, bankers or charge card please confirm when the issuer was notified:	

- If the loss occurred at the airport or on the aircraft we will require the Property Irregularity Report and this should be sent with this claim form.
- Please provide proof of the original purchase/ownership, i.e., receipts, bank/credit card statements, photographs, packaging, instructions manuals, valuations.
- Please note that we may make a deduction on the claim if proof of purchase is not provided and/or if wear-and-tear is applicable.
- If items have already been replaced please send the replacement invoice or receipt.

ITEM DETAILS		
Full description of item 1:		
Where purchased and date purchased:		
Price paid:	Cost now:	Amount claimed:
Full description of item 2:		
Where purchased and date purchased:		
Price paid:	Cost now:	Amount claimed:
Full description of item 3:		
Where purchased and date purchased:		
Price paid:	Cost now:	Amount claimed:
Full description of item 4:		
Where purchased and date purchased:		
Price paid:	Cost now:	Amount claimed:
Full description of item 5:		
Where purchased and date purchased:		
Price paid:	Cost now:	Amount claimed:

IMPORTANT	
In the event of a personal baggage loss, all incidents MUST be reported to the local police within 24 hours. An incident number and loss report must be obtained and attached.	
Please provide details of any other insurance policy that you have that may contribute to this loss, e.g., household insurance, private medical insurance, personal travel insurance, credit card insurance, etc.:	
Name of Insurer:	Policy Number:
Correspondence Address:	

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F. LOSS OF PASSPORT – Section 7 of the Policy
Please confirm where the passport was lost:
Please provide details of the expenses incurred to replace the passport, including receipts:

G. PERSONAL ACCIDENT – Section 2 of the Policy
When did the injury, or (in the event of a fatality) death occur? Please detail the nature of the loss or how the death occurred:
Was the injury or cause of death as a result of natural causes?: ☐ Yes ☐ No If yes, please give details:
In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to International Claims Services.

For claims involving **Personal Liability, Legal Expenses** and **Hijack** please contact Expatriate Healthcare Claims directly with details of the incident.

H. DECLARATION

For Data Protection Purposes I/We acknowledge that any personal data secured from me/us as a result of this claim will be held and processed for insurance administration and claims investigation. For this purpose, the information may also be passed to selected third parties and reinsurers.

I/We consent to your processing of sensitive data about me/us and other persons who may be insured under the contract.

I/We understand that all personal data I/We supply must be accurate and I/We have the specific consent of those other persons insured to disclose their personal data.

I/We consent to the inquiry of information from other insurers, Credit and other information Agencies to check the answers we have provided and will authorize the release of such information.

I/We declare that on settlement I/We transfer all rights of subrogation and recovery to the Insurer and or/their Loss Adjuster. Please note that we have rights to salvage and we will exercise these rights where applicable.

I/We declare that, to the best of our knowledge, the information submitted in this form is correct and complete.

Insured Person	Policy Holder
Name:	Name:
Signature:	Signature:
Date:	Date:

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Payment Details		
Who would you like to be paid?:	☐ Primary Insured	☐ Other
If 'Other':		
Name:		
Address:		
How would you like to be paid?:	☐ Cheque/Check	☐ Bank Transfer
If 'Bank Transfer':		
Bank Name:		
Account Holders name:		
Address:		
Swift/Bank Routing Number:		
Account Number/IBAN:		
Settlement Currency:		

Check List

When returning the claim form, please ensure that all necessary supporting information is attached. Where there is insufficient information to substantiate your loss, your claim may be reduced or declined.

- ☑ Travel tickets & accommodation receipt – All Claims
- ☑ Copy of Passport – All Claims
- ☑ Proof of withdrawal for Money/foreign currency claim (Money)
- ☑ Police report-showing time and date of loss - within 24 hours of loss (Money/theft/loss claims)
- ☑ Carrier report-showing date of loss/delay (Baggage claims)
- ☑ Ticket/accommodation receipts for additional expenses (Cancellation/curtailment claims)
- ☑ Hospital Discharge summary (Medical/Hospital claims)
- ☑ Carrier Report, police report, public transport report showing reason and length or delay (Travel Delay)
- ☑ Please complete the attached Payment Instructions form.

Please return the completed for and all supporting information to, Expatriate Healthcare Claims Department:

- **Online claims submission available at:** http://www.expatriatehealthcare.com/how-to-claim.htm
- **Mail:** Expatriate Healthcare, John de Mierre House, Bridge Road, Haywards Heath, RH17 1UA, United Kingdom.
- **Fax**: +44 (0)870 112 8455
- **Email**: claims@expatriategroup.com