Medical Expenses

In order to support the process of your Medical Expenses Claim, we have put together a checklist to ensure you include the correct paperwork to support your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

Your Checklist of Documents Required

Please Note: We do not require original receipts, passports, EHIC's, death certificates or CD's for the initial claims set up, a top tip is to take a clear photo of your receipts and email them over to us.

Please ensure you keep the originals safe in case we do still require them.

No need to staple your papers either; the full contents of each envelope we receive are immediately scanned onto our computer system, and having to remove staples may damage the papers which could delay your claim!

- ☐ **Completed claim form** – You should complete all sections relevant to your claim, save a copy and email to us with all the requested supporting documentation as listed below.
- ☐ **Insurance certificate** – Including any medical declarations. This will confirm who you purchased your insurance from and the cover agreed.
- ☐ **Booking invoice(s)** – With full details of your trip booking (inbound and outbound flight, accommodation, transfers etc.) These documents need to include the booking date, travel dates, destination, names of all people booked to travel/ stay and confirm how much money you paid for the booking.
- ☐ **If travel was to Europe** – Please complete the disclaimer form on page 4 and send a copy of your EHIC.
- ☐ **Medical/ Dental Reports** – Please provide all medical reports relating to the incident. Reports must show the name of the patient, details of admission, the condition/ injury treated and the treatment provided. Any early return or extended stay resulting from the condition must be clarified by the treating doctor in writing.
- ☐ **Medical/ Dental Invoices** – This should detail the treatment given and a breakdown of the costs associated with this – if you paid in resort then we will need conformation that this was paid and a credit card/bank statement that shows the transaction so that the correct exchange rate can be used. Please note you will need to number reference all receipts to coincide with the completed claim form.
- ☐ **If your claim occurred in France** – Please sign all medical documents called "Feuille des Soins" in the box marked "Signature de l'assuré(e).
- ☐ **Proof of Payment** – This will need to be in the form of a receipt or an invoice, if paid by debit card or credit card a copy of your statement showing the Sterling conversion will be needed otherwise the exchange rate will be calculated based on published rates. If a large medical bill has been paid in cash, we will also require evidence of the funds used to settle the invoice. (cash withdrawal).

- ☐ **Additional hotel invoice and proof of payment** – If you needed to arrange alternative accommodation during the trip dates or an extension of the trip, the hotel invoice must show the name of the person using the hotel, the dates used, and the costs involved per day. No costs for food and drink or specific room charges (telephone/tv/room service) can be claimed against the policy.

- ☐ **Invoice for new flights and proof of payment** – If you returned home early or were delayed in returning home, we will need details of the new flights - the travel document and invoice must show the name of the person using the flight, the date of the flight, and the cost of the flight. If our team arranged these flights then we will have this on file already. We will need evidence of any refunds you have either received or are entitled to receive regarding your unused pre-booked travel arrangements.

- ☐ **Details of any other party who may be responsible for / provide cover for this claim** – This can include other travel insurance policies held with your bank or card provider, and third-party details if the cause is due to the actions of another.

Please make sure you keep the originals documentation and receipts unless we request them from you. If we do then please send them to us by recorded delivery and keep a receipt of proof. Please note that all documentation is destroyed after 3-months to comply with our responsibilities under the Data Protection Act.

Please be aware that in all instances we accept the original reason or circumstances described when a claim is notified or submitted, any change in circumstances or claim description that is submitted at a later date will be referred to our investigations team in line with our fraud prevention policy.

Please consider the environment before printing this checklist. We **do not** require the checklist to be printed and returned.

Medical Expenses

Email: claims@policyholderclaims.co.uk
Post: Claims, 1 Tower View, Kings Hill, West Malling, Kent, ME19 4UY

Top Tip: If you tap or click the box you can type away & email your claims form with the relevant documents to us.

Claims Reference Number, if already known:	
Assistance Team Advice Line Reference:	

Details of the Claimant

Title:		First Name:		Last Name:	
Address:					
Post Code:		Email Address:			
Date of Birth:	DD/MM/YYYY	Telephone:			
Bank Name:		Name on Account:			
Account Number:		Account Type: (e.g. premier, gold, reward)			
Sort Code:		SWIFT/BIC (for payments outside of the UK)			
IBAN (International Bank Account Number):					

For your convenience and to offer an efficient smoother service, we will pay any claim settlement due directly into your bank account. *We do not accept liability for any payment misdirection or delay due to the incorrect bank details being provided by you.*

Details of the Insurance Policy and Trip

Policy Number:		Date of Issue:	DD/MM/YYYY
Insurance Company Name:		Date Trip Booked:	DD/MM/YYYY
Policy Cover Level (e.g. silver, gold, standard etc.)		Destination:	
Trip Date From:	DD/MM/YYYY	To:	DD/MM/YYYY
Do you or any of the insured party have any other travel insurance cover? If yes give details.			

Details of Claim

Date of Injury/Illness:	DD/MM/YYYY
Nature of illness / injury and details of medical attention sought. If injury, please give details of how and where it happened and contact details of any other parties you consider responsible for your injury.	

Hospital Name:			
Public or Private Hospital:			
Doctor Name:			
Date of Admission:	DD/MM/YYYY	Date of Discharge:	DD/MM/YYYY

Was your European Health Insurance Card (EHIC) accepted by the treating Doctor/Hospital?	Yes ☐	No ☐

Do you have Private Health Insurance?	Yes ☐	No ☐	
If Yes, Name and Address:			

GP Name:	
Practice Address:	

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.

Medical and Other Expenses (please list all expense making sure to number your receipts to help us identify them and continue on another word document if needed):						
Receipt No.	Date:	Description of Item:	Name of Service Provider:	Amount (Inc. currency:	Paid Y/N:	Method of payment:
	DD/MM/YYYY			£		
	DD/MM/YYYY			£		
	DD/MM/YYYY			£		
	DD/MM/YYYY			£		
	DD/MM/YYYY			£		
	DD/MM/YYYY			£		
	DD/MM/YYYY			£		
	DD/MM/YYYY			£		
			Total:	£		

If we require information from your Doctor in respect of your claim you have certain rights under the Access to Medical Reports Act 1988: -

- Your consent* is required before the insurer or anyone acting as their agent can apply for a report and you may see the report before it is supplied to the insurer 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 to give your consent*.
- At no time will the report be sent to the insurer 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 are your responsibility, as they are not covered by this policy.

Declaration

I consent to agents acting on behalf of the insurer as detailed within the policy documents, seeking medical information from any doctor who has 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).

Signature:		Date:	DD/MM/YYYY
Print Name:			

Claim Declaration

- I/We declare that all the details provided above are true and accurate to best of my knowledge.
- I/We give consent to agents acting on behalf of the insurer to seek recovery of monies paid where other insurers cover the same risk, or from third parties who may be 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 or exaggerated that this will invalidate the whole claim and the agent may seek to recover any costs through the civil courts.
- I/We understand that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf, and I confirm that I understand that neither agents acting on behalf of the insurer or the underwriters of the policy will accept the responsibility if any payments are not distributed proportionately.

Signature:		Date:	DD/MM/YYYY
Print Name:			

Consent

I give my authority for you to communicate with the following people who I may wish to contact you, or to be a point of contact for me, whilst my claim is being finalised.

Full Name:	
Full Name:	

Your Signature:		Date:	DD/MM/YYYY

Must be completed when Medical Expenses were incurred in Europe.

Dept for Work and Pension
Tyne & Wear

I consent to agents acting on behalf of the insurer to seek reimbursement of medical expenses paid by them arising out of medical treatment received in:

Country:	

On:

Date:	DD/MM/YYYY

I declare that the information given on this form is correct and complete

Signature:		Date:	DD/MM/YYYY

Please complete all sections below whether the costs relate to yourself or a child.

Your full name:	
Your date of birth:	DD/MM/YYYY
Full name of child (if applicable):	
Date of birth of child (if applicable):	DD/MM/YYYY
Your address in the UK:	
Address of child if different:	
Your nationality:	
Nationality of child (if applicable):	
National Insurance Number (in case of child under 16 give parent's)	

Trip Date From:	DD/MM/YYYY	To:	DD/MM/YYYY

Dates of Treatment From:	DD/MM/YYYY	To:	DD/MM/YYYY