

Dear Sir/Madam,

We understand that you need to make a claim on your travel insurance policy.

To ensure we can assess and finalise your claim as quickly as possible and to avoid unnecessary delays, please follow these simple steps:

1. Completing your claim form:

- Fully complete the enclosed claim form in as much detail as possible.
- Please write clearly.
- Please submit your claim within 31 days of your return date.

2. What you need to include with your claim form:

- Use the checklist and obtain all the required ORIGINAL documents to substantiate your claim. Copies are not acceptable unless indicated.
- Any other documentation and information you want us to consider.

3. Before you send your claim:

- Double check your claim is complete and sign the declaration on page 1.
- We recommend you keep a copy of your claim for your own records.

4. Where to send your claim:

- *Please post your claim to:*

Customer Care Claims Department
PO Box 9180
Chelmsford
Essex
CM1 9AG

- For your peace of mind you may wish to consider using Recorded or Special Delivery.

Once we receive your claim we aim to correspond with you within ten business days.

If you have any queries, please don't hesitate to contact us for assistance*.

Kind regards,

Cover-More Insurance Services Limited.

* Calls may be recorded or monitored for reference and training purposes.

Cover-More Insurance Services Limited
United Kingdom • Australia • New Zealand

Level 2, 31 Springfield Road, Chelmsford, Essex, CM2 6JE
p 01245 272408 f 01245 272400 e enquiries@covermore.co.uk

www.covermore.co.uk

...making travel insurance easy

Travel Insurance Claim Form (UK)

THIS PAGE MUST BE COMPLETED FOR ALL CLAIMS

- Please ensure you provide all requested information and documentation. If you need help with your claim please telephone us. If you don't provide what is required your claim may be delayed or not paid.
- Please keep a copy of your claim.
- We shall respond to your claim within ten business days from the day we receive it.

OFFICE USE ONLY: NEW EXISTING

Claim Number:

Date received:

Your Details

Please tick preferred option for correspondence

Email Post

Title First name

Family name

Date of Birth Passport Number

Occupation

Email Address

Home Address

County Post Code

Home Phone Mobile

Work Phone Fax

Name of Your Travelling Companion Their contact number

Your Policy

Policy Number Date Issued

Travel Agency Name & Location Travel Consultant's Name

Date insurance paid for Date travel arrangements booked

Date departed Date returned

Your Health

Did Self Assessment of an Existing Medical Condition apply to you?

Yes No

If yes, advise that condition:

Did you apply and pay for any Existing Medical Condition cover? Yes No

If yes, please provide the reference number below:

Settlement of Your Claim

Write Clearly To Avoid Delays

If your claim is approved for payment we will deposit the amount payable directly to a bank account you nominate. *NOTE: We cannot deposit to credit card or non-UK accounts.*

Sort Code (Must be 6 digits) Account Number (Must be 8 digits)

Name of Account Holder Name of Bank

Other Insurance/claims

Can you claim/have you claimed from any other source? (e.g. airline, transport provider, travel agent, third party etc.) Yes No

Details Amount Received

Do you have private health insurance? Yes No

Name of fund Policy Number

Can you claim from them for this event? Yes No

If yes, include your statement of benefits giving evidence of the amount received.

Have you made a travel insurance claim in the past? Yes No

If yes, please give details

Date Company Name

Amount Claimed Type of claim

Certain credit cards may provide basic travel insurance cover which may also cover your loss. Do you have credit card/s? Yes No

If yes, with which provider and which card type/s?

Provider (e.g. Barclays) Type (e.g. Gold Visa)

Did you purchase part or all of your travel on the card/s? Yes No

Warning

To avoid passing the cost of dishonest and fraudulent claims on to you, our honest policy holder, we are strongly committed to investigating claims. We try to conduct/ finalise investigation quickly and with minimal disruption. If your claim is found to be fraudulent the claim will be declined. All cases of fraud will be reported to the Police and can result in imprisonment and civil action by the insurers.

Your Declaration: Important

I/We declare that all statements and particulars stated on this form and all documents submitted are true and correct. I/We have not withheld any material information connected with this claim that will inhibit the insurers ability to make a fair and reasonable assessment of my claim.

I/We assign to insurers all rights of recovery/salvage against any person or organisation and will cooperate to secure such rights.

I/We acknowledge that the underwriter or it's agents may give to and obtain from any other insurer or insurance reference bureau, information relating to this or any other insurance held by Me/Us, or any claim made by Me/Us and I also authorise any other insurer to provide information relating to this or any claim made by me.

Claimant's Name Claimant's Name

Signature Signature

Date Date

Overseas Medical, Dental & Related Expenses

ALL CLAIMS: Please tell us what happened in as much detail as possible

Date of incident	Time	Country	Location
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> AM/PM	<input type="text"/>	<input type="text"/>

Explanation (Please attach a letter if more space is required)

Person whose state of health caused the claim:

Family name	First name
<input type="text"/>	<input type="text"/>

Date of birth	Relationship of that person to you
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

Has the illness/injury occurred before? Yes No

If yes, please give details

Were you treated as a hospital inpatient overseas? Yes No

Date & Time Admitted	Date & Time Discharged
<input type="text"/>	<input type="text"/>

Did you contact the 24 hour Emergency Assistance company?

Yes No

If no, why not?

Medical and Dental Expenses – Please list each bill/ receipt separately

Date	Provider's Name	Description/Reason	Amount	Currency	Paid Yes/No	Office use only

Did you pay the policy excess directly to the provider? Yes No If yes, please attach the original receipt

Are you expecting to receive further bills for this event? Yes No If yes, please give details below

Medical Authority

To be completed by the person whose state of health caused the claim or the Executor of the Estate, if applicable:

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for the condition/s which resulted in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original

Family name	First name	Date of birth	Signature
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

Name of usual doctor in the UK	Doctor's phone number	Doctor's fax number
<input type="text"/>	<input type="text"/>	<input type="text"/>

Doctor's address (include post code)

Overseas Medical, Dental & Related Expenses

Additional Expenses

1. What were the unexpected costs incurred?			2. If the claimed event had not happened how much did you expect to pay for accommodation/transport in the corresponding period?			3. Deduct 2 from 1 and write amount here. This is the maximum amount you can claim under this section
Description of cost	Amount	Currency	Description of cost	Amount	Currency	

Name of person whose state of health/death caused the claim

Family name

First name

Date of birth

Relationship of that person to you

Documentation We Require To Process Your Claim:

Please check your claim and before you send it to us please ensure that you attach the following ORIGINAL documents:

Attached (Please tick)

ALL CLAIMS

Your original travel itinerary, travel tickets, booking invoice to confirm travel

A copy of your Certificate of Insurance.

OVERSEAS MEDICAL

An original medical report confirming the nature of the illness or injury for which treatment was sought .

The original, itemised account/s showing a breakdown and description of the amounts claimed/paid.

The Medical Authority must be completed by the person whose state of health caused the claim or the Executor of the Estate.

If your claim arose due to the involvement of another party, please provide all relevant reports (e.g. police report, hotel report, embassy report) and the full name, address and contact details of the other person/s involved.

If your plans changed due to a policy holder's health, a medical certificate from the medical practitioner consulted (whilst on the trip) confirming the need to change your plans.

OVERSEAS DENTAL

An original dental report giving full details of the dental problem for which you sought treatment. N.B. A policy limit applies to Dental cover.

FUNERAL EXPENSES

We extend our sincere sympathies.

Original itemised receipts for the costs incurred to return the policy holder's body or ashes to the UK.

An original medical report confirming the nature of the illness or injury which caused the death.

If due to an accident, an original police report is required.

If the accident happened in an area or building in which a business operates, for example a hotel, amusement park, restaurant, airport, bus, aircraft etc, an incident report must also be obtained from the official party for evidence and recovery purposes.

A full copy, not an extract, of the Death Certificate (must state cause of death).

The Medical Authority must be completed by the Executor of the Estate.

BRINGING YOU HOME IN AN EMERGENCY

Original itemised receipts for additional accommodation and travel expenses claimed.

An original medical report confirming the nature of the illness or injury which gave rise to your claim.

The Medical Authority must be completed by the person whose state of health caused the claim or the Executor of the Estate.

If you returned home due to the illness, injury or death of a Relative or Business Associate you must also have that person's USUAL general medical practitioner complete the MEDICAL CERTIFICATE.

HOSPITAL STAY

An original medical report confirming the nature of the illness or injury which gave rise to your claim.

A hospital report which confirms the hospital date & time admitted to and discharged from hospital.

Please include any other documentation you wish us to consider.

If you have not provided any of the required documents please tell us the reason why in writing.

MEDICAL CERTIFICATE - To be obtained at the claimant's expense from the patient's usual doctor in all cases of Amendment or Cancellation Costs resulting from accident, illness or death

IMPORTANT: The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries. **** PLEASE USE BLOCK LETTERS ****

1. Full name of patient

Date of birth 2. Patient's relationship to claimant

3. Are you the patient's usual G.P.? Yes No
 If **Yes**, for how long?

If **No**, please provide full details of the patient's usual G.P.

4. a) Please give a precise diagnosis of the illness, injury or cause of death.
 If an injury, how was it sustained?

b) If due to a pregnancy, on what date was the pregnancy confirmed?

c) How many weeks pregnant was the person on this date?

d) Was the conception medically assisted? Yes No

e) Have there been complications with this or any other pregnancy? Yes No
 f) Expected delivery date:

5. Date of onset of illness, injury or date of death

6. Date on which you were first consulted in relation to this

7. Date referred to specialist

8. Date tests prescribed & carried out

9. Date results advised to patient

10. Date there was a deterioration

11. Name and address of specialist/surgeon

12. Have you or anyone else previously treated the patient in respect of the same/similar/related illness or injury as described in question 4?
 Yes No

If **Yes**, a) state if same illness or injury, or specify similar/related illness or injury (please give full details including dates)

13. Was the patient advised to continue this treatment and/or medication:
 • Until departure on this journey Yes No
 • Whilst on this journey Yes No

14. Was the patient hospitalised? Yes No
 If **Yes**, advise admission date

15. a) Please provide details of the patient's health at the time when the insurance was issued and the likelihood of the patients health causing a claim (see claimant for exact date)

b) Was the patient being treated for the condition which caused the cancellation or curtailment at or prior to the date the insurance was issued?
 Yes No

16. Was the patient on a waiting list for admission to hospital? Yes No

If **Yes**, please state:
 Date they were on the waiting list Date of admission

17. Was it reasonable of the claimant to continue with travel plans considering the answer to the other questions? Yes No

18. Are you prepared to certify that solely due to the condition described in question 4, the claimant/s was/were required to cancel or curtail the travel arrangements? Yes No

THE FOLLOWING QUESTIONS ONLY APPLY IF THE PATIENT WAS IN THE TRAVELLING PARTY

19. Date it became apparent the patient would not be able to travel (if applicable)

20. How long was or will the patient be prevented from travelling?
 from to

21. Had the patient planned to travel against your prior advice?
 Yes No If **Yes**, please give details:

22. Did the patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment? Yes No

If **Yes**, please give details:

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

Doctor's Name

Doctor's Signature Date

Qualification

Telephone Facsimile

Address

Company Stamp