# MEDICAL & OTHER EXPENSES CLAIM FORM

| **Claim Number:** A claim number will be allocated once this form is returned | |
|---|---|

**Claims Settlement Agencies Limited**
308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD
Tel: 01702 842063 Fax: 01702 427173
email: info@csal.co.uk www.csal.co.uk

**Please use the above address for ALL correspondence & quote the above Claim Number in ALL subsequent communication.**
**When the Claim Form is received we aim to process it in five working days.** **Date:**
***If original documents are being sent, we recommend sending via Recorded Delivery.***
***Please ensure you keep copies for your own records if posting original documents.***

This claim form is being provided to you as requested in order that you can make a claim for Medical & Other Expenses under the terms and conditions of your travel insurance policy.

Below is a Document Check List – please ensure you provide the correct documentation when submitting your claim as failure to do so may cause delays.

We suggest you keep a copy of this claim form and other documents for your own records.

| **IMPORTANT DOCUMENT CHECK LIST**<br>Have you enclosed or previously provided the following documents? | ✓ **PLEASE TICK** | | | |
|---|---|---|---|---|
| | Enclosed | Previously sent | Not available | Not applicable |
| **CERTIFICATE OF INSURANCE** (or other proof of payment of insurance premium i.e. the Tour Operators booking invoice) | ☐ | ☐ | ☐ | ☐ |
| **HOLIDAY BOOKING INVOICE** as issued by the booking Agent & Tour Operator (if applicable) | ☐ | ☐ | ☐ | ☐ |
| **ORIGINAL RECEIPTS for any costs being claimed** | | | | |
| **MEDICAL EVIDENCE to support details of illness or injury** | ☐ | ☐ | ☐ | ☐ |
| **DEATH CERTIFICATE** (if applicable) | ☐ | ☐ | ☐ | ☐ |
| **EVIDENCE OF HOSPITAL ADMISSION AND DISCHARGE**<br>(only applicable if the Claimant was an in-patient in hospital) | ☐ | ☐ | ☐ | ☐ |
| **ORIGINAL TRAVEL TICKETS** (i.e. flight coupons/ferry tickets) | ☐ | ☐ | ☐ | ☐ |
| **ADDITIONAL TRAVEL TICKETS** (if applicable) | ☐ | ☐ | ☐ | ☐ |

**PLEASE ANSWER ALL QUESTIONS IN BLOCK CAPITALS – THANK YOU FOR YOUR CO-OPERATION**

| **CLAIMANT DETAILS** | | |
|---|---|---|
| Q01. Claimant's details: Title: | First Name(s): | Surname: |
| Q02. Date of Birth: | Present Age: | |
| Q03. Occupation: | | |
| Q04. Address: | | |
| | | Post Code: |
| Q05. Home Tel: | Mob Tel: | Work Tel: |
| Email: | | |

 Registered in England Number: 02558156

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## HOLIDAY & INSURANCE DETAILS

| | | | |
|---|---|---|---|
| Q06. Holiday booking date: | Period from: | Period to: | Number of days: |
| Q07. Number of people in your party: | Q08. Holiday Country & Destination: | | |

Q09. Name of the Travel Insurance provider:

Q10. Travel Insurance Policy Number (as shown on your insurance schedule):

Q11. Policy issue Date ***(very important)***:

Q12. Method of payment for the holiday: Credit Card: ☐ Debit Card: ☐ Cheque: ☐ Cash: ☐ Other: ☐

If credit card was used please provide details: Card Issuing Company:

## CLAIM DETAILS

Q13. Date, Time & place the injury or illness occurred:

| | | |
|---|---|---|
| Date: | Time: am: ☐ pm: ☐ | Place: |

Q14. The nature of the injury or illness and the FULL circumstances in which it arose (especially in the case of an injury). Please continue on a separate sheet if necessary

Q15. If injury, name and address of any witnesses:

Q16. Were the Assistance Company contacted? **YES:** ☐ **NO:** ☐ If 'YES' please provide name of company:

| | |
|---|---|
| Assistance Company Ref No (if known): | What type of assistance did they provide? |

Q17. Was the holiday representative involved? **YES:** ☐ **NO:** ☐ If 'YES' please provide a copy of any report obtained

Q18. Were you admitted to hospital? **YES:** ☐ **NO:** ☐ If 'YES' please advise the name of hospital:

| | | | |
|---|---|---|---|
| Date admitted: | Time: am: ☐ pm: ☐ | Date discharged: | Time: am: ☐ pm: ☐ |

| | |
|---|---|
| Q19. On what date did you return to the UK? | Giving a total extended stay of days |

Q20. What items are you claiming for? **Please complete the CLAIM EXPENSES SCHEDULE on the next page**

## E111 & OTHER INSURANCE & THIRD PARTY DETAILS

Q21. Did you obtain the form E111 or EHIC (European Health Insurance Card) from the DSS to entitle you to reduced medical costs in an EEC country and was this used? **YES:** ☐ **NO:** ☐ If you obtained the form, and still have it in your possession, please forward it to us:

| | |
|---|---|
| Form obtained: **YES:** ☐ **NO:** ☐ | Form attached: **YES:** ☐ **NO:** ☐ |

Q22. Do you have any other private medical insurance i.e. BUPA, PPP or any other insurance that may cover these expenses? You may be able to reclaim your excess if you do **YES:** ☐ **NO:** ☐ If 'Yes' please provide Policy Holder Name (if different):

Company Name & Address:

| | |
|---|---|
| Membership Number: | Policy Number: |

| | |
|---|---|
| Q23. Has this claim been submitted (or will it be) to the DSS or other insurer? **YES:** ☐ **NO:** ☐ | Their ref (if known): |

Q24. Was the injury or illness caused by another party? **YES:** ☐ **NO:** ☐ If 'YES' please provide the name and address of the other party and full reasons why you or your advisors consider they were to blame. Name & Address:

Reasons:

Q25. Has a claim been made against the other party named in Q24? **YES:** ☐ **NO:** ☐ If 'YES' please provide details and the name, address and reference of any company handling the matter on your behalf:

| | |
|---|---|
| | Reference: |

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## PREVIOUS CLAIMS

Q26. Have you or any other person named on this form ever made any previous claim for medical or other expenses against this or any other Insurer in the past 5 years? **YES:** ☐ **NO:** ☐ (Please continue on a separate sheet if necessary)

| | |
|---|---|
| a)Date: | Incident: |
| Insurers / Adjuster: | Reference: |
| b)Date: | Incident: |
| Insurers / Adjuster: | Reference: |

Q20. **CLAIM EXPENSES SCHEDULE** - Please continue on a separate sheet if necessary

| Nature of Expense | Name of Supplier | Currency | Amount | ✓ Please tick if you paid this | ✓ Please tick if Unpaid and you want us to Settle Direct |
|---|---|---|---|---|---|
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | | | ☐ | ☐ |
| | | **TOTALS:** | 0 | | |

## POLICY EXCESS - IMPORTANT!

The Policy Excess is the amount deductible from each and every claim unless an Excess Waiver applies.

If you require us to pay any bills direct, please confirm below whether the Policy Excess was paid and submit a receipt to show the payment.

If you do not have an Excess Waiver and did not pay the Policy Excess to the Doctor/Hospital at the time of treatment then please remit a cheque payable to 'Claims Settlement Agencies Limited' for the appropriate sum (please refer to your Policy Conditions for details of the amount).

Q27. Excess Paid? **YES:** ☐ **NO:** ☐ If 'YES' to whom (name of Doctor/Hospital):

| | |
|---|---|
| Q28. Currency Used: | Q29. Amount Paid: |

Q30. Are further accounts to be submitted? **YES:** ☐ **NO:** ☐ If 'YES' please provide details:

Q31. To whom do you wish any personal payment to be made if different to the Claimant named in Q01? Name:

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## DATA PROTECTION NOTICE

**Personal Information** – means information that identifies and relates to you or other individuals (i.e. your dependants). By providing **Personal Information** to Claims Settlement Agencies you give us permission for its use as described below. Full details about our use of **Personal Information** can be found in our full Privacy Notice at www.csal.co.uk/privacy-policy or you may request a copy using the contact details above.

When providing **Personal Information** about another individual to us, you confirm that you are authorised to provide it for use as described below.

**Types of Personal Information we may collect and why:**
Depending on our relationship with you, **Personal Information** collected may include:

- identification and contact information,
- payment card and bank account,
- credit reference and scoring information,
- sensitive information about health or medical condition,
- and other **Personal Information** provided by you.

**Personal Information may be used for the following purposes**:

- Insurance administration, (communications, claims processing and payment)
- Decision-making on provision of insurance cover and payment plan eligibility,
- Assistance and advice on medical and travel matters,
- Management and audit of our business operations,
- Prevention, detection and investigation of crime, (fraud and money laundering)
- Establishment and defence of our legal rights,
- Legal and regulatory compliance, including compliance with laws outside your country of residence,
- Monitoring and recording of telephone calls for quality, training and security purposes.

**Sharing of Personal Information**:
**Personal Information** may be shared with our group companies, Brokers and other distribution parties, Insurers and Reinsurers, Credit Reference Agencies, healthcare professionals and other service providers. **Personal Information** may be shared with other third parties (including government authorities) if required by law. **Personal information** (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

**Security and retention of Personal Information:**
Appropriate legal and security measures are used to protect **Personal Information**. All third party service providers are also selected carefully and required to use appropriate protective measures. **Personal Information** will be retained for the period necessary to fulfil the purposes described above.

**International transfer:**
Due to the nature of our business, **Personal Information** may be transferred to parties located in other countries with different data protection laws than in your country of residence.

**Data requests:**
To request access or correct inaccurate **Personal Information**, or to request the deletion or suppression of **Personal Information**, or object to its use, please e-mail: info@csal.co.uk and mark for the attention of the Data Controller, or write to Data Controller, 308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD.

**DECLARATION** I declare that the whole of the statements made and any other supplementary statements forming part of this claim are true in every respect and understand that a false declaration may invalidate my claim and could result in prosecution. I give permission for my **Personal Information** to be used and shared in the ways described above. I confirm that I will not provide any **Personal Information** about another person without that person's permission.

## CUSTOMER DECLARATION – To Be Completed By ALL Persons Claiming Aged Over 16

Claims Settlement Agencies Ltd, agents and business partners may contact anyone who can give them information relevant to my claim. I/ We confirm that the information that I/ we give is true and if any of the information given by me/ us (or anyone on my/ our behalf) is incorrect, I/ we agree that such inaccuracy may cause me/ us to forfeit my/ our rights under the policy.
In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.
Payments: Subject to admission of liability, we will make payment in favour of the claimant (aged over 16) as detailed in question 01 above but if an alternative payee is required please state below. I/ We have read and fully understood the above declaration.

| Insured Name | Signature | Date of Birth | Date of Signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**PLEASE ENSURE THAT ALL RELEVANT DOCUMENTATION IS THE ORIGINAL AND NOT A PHOTOCOPY**

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## DETAILS OF OTHER INSURANCES - Failure to provide the information requested below may delay your claim

Some bank accounts and credit cards come with Travel Insurance benefits and if you did have cover of this nature we may seek a contribution from the other company once your claim is settled. A loss that is covered by more than one policy will routinely be shared so each Insurer can keep their premiums as competitive as possible, but the contributing Insurer cannot alter the price of terms of its policy unless there has been a claim direct from a policyholder.

| | |
|---|---|
| Name of Bank / Building Society: | |
| Type of Account: | |
| Sort Code: | Account Number: |
| Did you pay for your trip with a credit card? **YES:** ☐ **NO:** ☐ | |
| Card Number: | Card Type e.g. Platinum / Gold / Premier: |
| Do you or any of the insured party have any other travel insurance that may cover you for this claim? ☐ ☐ | |
| Name of company: | |
| Policy Number: | |

## SETTLEMENT DETAILS

Claims payments made by BACS transfer or other electronic banking system will be made and credited to your account.

By entering your bank account details, you confirm that CSAL has your full authority to remit monies directly to that account by the BACS or other electronic banking system. You also accept that, providing payment remitted to the bank account designated by you, CSAL shall have no further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.

| | |
|---|---|
| Name of account holder: | |
| Type of current account e.g. Platinum / Gold / Premier: | |
| Name and address of Bank / Building Society: | |
| | |
| Sort Code: | Account Number: |

## BROKER

| |
|---|
| Did you arrange your insurance via a broker? If so do you consent to us discussing your claim with them directly (if required)? **YES:** ☐ **NO:** ☐ |
| Name of Broker: |

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