

## CLAIMS INTERNATIONAL

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# MEDICAL EXPENSES AND CURTAILMENT CLAIM FORM

## WEB CLAIM

Dear Sir or Madam

Here is your claim form as requested. Please complete it fully and return to us.

**PLEASE ENSURE YOU SIGN AND DATE THE FORM ON THE FINAL PAGE - FAILURE TO DO SO WILL DELAY YOUR CLAIM.**

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form. **Thank you.**

### VERY IMPORTANT

Please ensure you enclose the following **ORIGINAL** (not photocopied) documents (if not already sent):

- |  |                              |                             |
|--|------------------------------|-----------------------------|
| (a) Proof of insurance, such as the numbered certificate or validation receipt or tour operator's invoice showing insurance. | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (b) Medical evidence to support details of illness or injury.  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (c) Original travel tickets (ie. flight coupon/ferry/coach tickets).   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (d) In cases of death, a <b>photocopy</b> of the death certificate is required.  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (e) The holiday booking invoice or other documents issued as evidence of holiday/trip cost and dates.                        | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (f) Original receipts for costs incurred.  | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (g) If the claimant was a hospital in-patient, evidence to show admission and discharge dates.                               | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (h) If the holiday was curtailed any additional travel tickets (flight coupons/ferry tickets/rail tickets/taxi costs).       | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| (i) Any accident report form or Police report if applicable.   | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

### CLAIM FORM NOTES

Travellers from the UK who are eligible are entitled to free or reduced-cost emergency medical treatment in the other EEA (European Economic Area) countries (which includes the European Union states). In order for us to seek reimbursement of our outlay, please could you provide the nationality and National Insurance Number of the patient, where requested. If the patient is aged 16 or under, the details of their parent/guardian should be provided. If aged between 16 and 19 and still in full time education, a parent or guardian will need to provide these details. If you are in possession of an EHC (European Health Insurance Card) please do not send it through to us.

## EMAIL AND TELECLAIMS

If you have no objection, in an effort to promote speedier and more customer-friendly claims handling we may find it easier to email you or telephone you during our normal working hours to discuss your claim and/or request further details. Please confirm your email address and/or advise us of any relevant numbers on which can be reached in the spaces below.

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

**CLEAR BLOCK CAPITALS MUST BE USED PLEASE**

<b>1</b> Claimant's title: Mr / Mrs / Miss / Ms / Other (please specify)			
Forename(s)		Surname	
Nationality		National Insurance No.	
<b>2</b> Address			
Postcode			
<b>3</b> Telephone daytime	Telephone evening	Mobile Number	
<b>4</b> E-mail address			
<b>5</b> Occupation		Date of Birth	
<b>6</b> The destination and country of this holiday/trip			
<b>7a</b> The date of policy issue (this is important)	DAY:	MONTH:	YEAR:
<b>7b</b> The policy number and policy prefix (if relevant)	PREFIX:	NO:	
<b>8</b> The name of the travel agent who issued the insurance			
<b>9</b> The period of your holiday/trip giving total number of days	From:	To:	Total Number of days:
<b>10</b> The number of people covered by this policy			
<b>11</b> The tour operator from whose brochure you booked (if relevant)			
<b>12</b> The day on which your holiday/trip was first booked	DAY:	MONTH:	YEAR:
<b>13</b> Please tell us the date and resort in which the injury was sustained or the illness contracted:			
DATE: ..... RESORT: ..... COUNTRY: .....			
<b>14</b> Does the incident relate to an illness? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please provide a full description:			
.....			
<b>15</b> Does the incident relate to an injury? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please answer the following:			
a) Please provide a full description of the injury: .....			
.....			
b) Please provide full details of the circumstances surrounding the accident and attach any documentary evidence/reports:			
.....			
.....			
c) Do you consider anyone to blame for the accident? YES <input type="checkbox"/> NO <input type="checkbox"/>			
If YES, i) Please provide name, address, etc .....			
.....			
ii) Please detail the reasons you consider this person(s) to blame: .....			
.....			
<b>16</b> If the claim for illness or injury is for the curtailment of the trip, please provide full details of the reason for the curtailment and supply documentary evidence: .....			
.....			
<b>17</b> Does your claim involve a medical condition for which previous advice/treatment has been given? YES <input type="checkbox"/> NO <input type="checkbox"/>			
If YES, was this condition declared: YES <input type="checkbox"/> NO <input type="checkbox"/>			
If YES, please quote your reference number: .....			
<b>18</b> Was the medical assistance company contacted: YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please supply the following:			
Name of assistance service: .....		Reference if known: .....	
Assistance provided: .....			
<b>19</b> If you were admitted to hospital, please advise name of hospital: .....			
Date Admitted .....		Date Discharged: .....	
Total no. of full days as in-patient: .....			
<b>20</b> If the curtailment was due to death or illness in the United Kingdom, please advise the name of the person and the relationship to the claimant			
Name: .....		Relationship: .....	



## CURTAILMENT ONLY

### IMPORTANT

The circumstances leading to the curtailment of your holiday must be supported by the independent documentary evidence from the attending medical practitioner or other relevant 3rd party.

Names of all persons curtailing:	Total holiday cost per person excluding insurance premium:
-----	-----
-----	-----
-----	-----
-----	-----
Date you returned:                    ..... / ..... / .....	
Date you should have returned:    ..... / ..... / .....	

### OFFICE USE ONLY

Curtailment
Cost per day
No. of days lost
Gross £
Excess total
Nett £

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION

PRIOR TO RETURNING THE CLAIM FORM PLEASE STUDY THE POLICY WORDING AND READ THE TERMS AND CONDITIONS AS THEY RELATE TO YOUR CLAIM.

PLEASE NOTE NEITHER WE NOR INSURERS ARE RESPONSIBLE FOR THE COSTS OF OBTAINING DOCUMENTATION IN SUPPORT OF THE CLAIM.

#### WARNING

THE MAKING OF A FRAUDULENT OR KNOWINGLY EXAGGERATED CLAIM IS A CRIMINAL OFFENCE AND COULD RENDER THE OFFENDER LIABLE TO PROSECUTION.

THE INFORMATION ON THIS FORM WILL BE USED BY YOUR INSURER TO DEAL WITH ANY CLAIM. YOUR INSURER MAY ALSO PASS THIS AND ANY OTHER INFORMATION TO OTHER INSURERS AND ORGANISATIONS INVOLVED IN DEALING WITH ANY CLAIM. INSURERS ALSO SHARE INFORMATION TO PREVENT FRAUD.

#### DECLARATION

I/We declare that to the best of my/our knowledge and belief all information stated herein is correct and the company is subrogated with all rights I/we may have against a third party. Furthermore, by signing this documentation the patient also consents to Claims International Limited seeking reimbursement of medical expenses paid by them arising out of medical treatment received from the Department of Social Security and any relevant authority related thereto..

I/We have not withheld any information from insurers within my/our knowledge connected with this claim.

I/We agree to provide further information or documentation as may be reasonably required.

I/We subrogate and assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever else is necessary to secure such rights.

SIGNATURE OF CLAIMANT: \_\_\_\_\_

DATE: \_\_\_\_\_