

TRAVEL (MEDICAL EXPENSES) CLAIM FORM

Claimant's Name:

Policy Number:

Address:

Tel Number:

Email:

Details of person handling claim if different from above:

Name:

Tel Number:

Address:

Booked travel dates:

From: DD / MM / YY

To: DD / MM / YY

Date of accident / onset of illness: DD / MM / YY Country:

Circumstances of accident (if applicable):

Nature of injuries / illness:

Is this injury / illness connected to any injury / illness you have suffered from in the past?

Yes

No

If yes, please give details:

Date of Birth of person requiring treatment: DD / MM / YY

Details of expenditure:

Nature of Expenditure	To Whom Paid	Currency & Amount	Paid / Unpaid
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If bills are unpaid and direct settlement is required, please give name(s) and addresses of payee(s):

Please attach: Flight tickets or Tour operator's confirmation of booking, medical bills covering the full amount of the claim and receipts and/or bills for any additional expenditure incurred.

Total amount of claim: £

I declare that these particulars are true to the best of my knowledge.

Signature: _____

Date: _____