

Medical Expenses, Medical Disablement,
Emergency Dental & Hospital Daily Benefit
Claim Form



Dear Claimant,

Please ensure all relevant sections are completed and the supporting documentation is attached. This will enable us to assess your claim quickly.

WE WILL CONTACT YOU WITHIN 5 WORKING DAYS OF RECEIPT OF THE CLAIM FORM.

WE RESERVE THE RIGHT TO REQUEST THAT ORIGINAL RECEIPTS / REPORTS OR ANY OTHER DOCUMENTATION BE SUBMITTED IN ORDER TO SUBSTANTIATE THE CLAIM.

DOCUMENT CHECKLIST (Please tick accordingly)

	✓
Policy Certificate/Schedule and/or tour operator's invoice proving insurance cover	
Medical invoice to support details of injury/illness	
Original travel tickets/booking invoice	
In case of death, a photocopy of the Death Certificate	
Original invoices for all other expenses you may wish to claim	
Any accident report or police report if applicable	

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PERSONAL DETAILS

Title	<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms	Other	<input type="text"/>
Surname	<input type="text"/>	First name	<input type="text"/>
Date of Birth	<input type="text"/> DD/MM/YYYY	N.I number	<input type="text"/>
Address	<input type="text"/>		Please tick your preferred method of contact
	<input type="text"/>		
	<input type="text"/> Post code		
Telephone	<input type="text"/>	Mobile	<input type="text"/>
Email	<input type="text"/>	Occupation	<input type="text"/>

Please tick your preferred method of contact

- Email Post
 Mobile Telephone

POLICY DETAILS

Insurance brand	<input type="text"/>	<input type="checkbox"/> Single trip	<input type="checkbox"/> Annual multi trip
Policy number	<input type="text"/>	Date of issue	<input type="text"/> DD/MM/YYYY
Date of outward travel	<input type="text"/> DD/MM/YYYY	Destination	<input type="text"/>
Date trip booked	<input type="text"/> DD/MM/YYYY	Date of scheduled return	<input type="text"/> DD/MM/YYYY
Travel agent	<input type="text"/>	Tour operator	<input type="text"/>

CLAIM DETAILS

Onset date of illness or accident	<input type="text"/> DD/MM/YYYY	Place accident / injury / illness occurred	<input type="text"/>
Full description of illness / accident including nature of injuries	<input type="text"/>		
Have you suffered from a related medical condition in the previous 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If 'yes' was this condition declared?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Medical screening reference number	<input type="text"/>		
Did you extend your trip?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If 'yes' how long for?	<input type="text"/>		
Did you contact our 24hour emergency service?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
Were you hospitalised as a result of the illness / accident?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
If 'yes' please provide dates	From: <input type="text"/> DD/MM/YYYY	To: <input type="text"/> DD/MM/YYYY	
Name of treating doctor	<input type="text"/>		
Address of clinic / hospital	<input type="text"/>		

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CLAIM DETAILS

Medical Expenses Schedule (original documents required)				
e.g. doctor's fee, prescription, travel costs)	Name of Provider (doctor, hospital etc.)	Amount & currency claimed	Has this been paid by yourself?	If unpaid shall we pay direct to provider?

SUPPORTING FUNDS

If you have received payment from any other source, please declare from whom and the amount:

POLICY EXCESS

Did you pay the provider the policy excess?

Yes No

If "Yes", please provide details

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Were you in a European Economic Area?

Yes No

If "Yes", did you use your European Health Insurance Card (EHIC)?

Yes No

Your EHIC number

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HOSPITAL DAILY BENEFIT

Was the 24/7/365 medical assistance contacted? Yes No

(if Yes) Date

--

DD/MM/YYYY

Hospital name

--

Admission date

--

DD/MM/YYYY Time

--

HH/MM Discharge date

--

DD/MM/YYYY Time

--

HH/MM

If you were admitted and did not contact us, please state reasons why and enclose any medical report(s) along with any other supporting documentation.

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IMPORTANT INFORMATION, PLEASE READ-ACCESS TO MEDICAL REPORTS ACT 1988

It may be necessary to apply for a medical report from a Doctor who has cared for you, and we ask that you give your consent by signing the claim form declaration. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988, and the procedures for dealing with the reports. You do not have to give your consent, but if you do, you can say whether you wish to see the report (or have a copy of it) before it is sent to us. If you say you wish to see the report, we must tell you at the same time as we write to the Doctor and we must tell him / her you wish to see the report. You have 21 days to contact the Doctor about arrangements for you to see the report.

Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied (if you ask). If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his / her costs.

Once you have seen a report, before it is sent to us, the Doctor cannot submit it until he has your written consent. You can write to the Doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your view on any part which he will not amend.

The Doctor is not obliged to let you see any part of a report if, in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctors intentions towards you or if disclosure would likely to reveal information about you or the identity of another person who has supplied information about you, unless that person has consented to the information relates to, or has been supplied by a health professional involvement in caring for you. In such cases, the Doctor must notify you in writing and you will be limited to seeing any remaining part of the report. If it is the whole of the report that is affected, he / she must not send it to us unless you give your written consent.

I HAVE BEEN INFORMED OF MY STATUTORY RIGHTS UNDER THE ACCESS TO MEDICAL REPORTS ACT 1988 AS HIGHLIGHTED ON PAGE 4 AND CONSENT TO MAYDAY TRAVEL CLAIMS OBTAINING A FURTHER MEDICAL REPORT SHOULD IT BE NECESSARY. IN THAT EVENT I DO / DO NOT WISH TO SEE (OR HAVE A COPY) OF THE MEDICAL REPORT BEFORE IT IS SENT TO MAYDAY TRAVEL CLAIMS.

Claimant name	Claimant signed	Date
		DD/MM/YYYY

INFORMATION WE NEED FROM YOU FOR POSSIBLE RECOVERY OPPORTUNITIES

Your Travel Policy has conditions attached whereby you must provide us with any information that assists any recovery actions. This is a standard practice in the insurance market and contributions made from other insurance cover serves to keep the costs of your premiums down. The information provided should not affect your renewal premiums, or no claims discount.

Please answer the following questions and provide details as required. For questions that require a YES / NO response, please tick the appropriate boxes. Failure to do so may delay your claim.

1. Do you have a bank account? Yes No

A bank account you hold may offer Travel Insurance cover as part of the benefits. Under no circumstances will your bank account information be used other than to obtain a contribution from the Travel Insurance provider. This will not affect your bank account in any way.

Name of bank	<input type="text" value="(e.g. HSBC)"/>	Type of account	<input type="text" value="(e.g. SILVER/GOLD)"/>
Account holder name	<input type="text"/>	Account number	<input type="text"/>

2. Was a credit card or debit card used to pay all or part of the trip cost?
(Certain credit or debit cards provide an element of travel cover) Yes No

Card issuer	<input type="text"/>	Type of card	<input type="text" value="(e.g. VISA)"/>
Card holder name	<input type="text"/>	Card number	<input type="text"/>

3. Do you hold any Private Medical Insurance? Yes No

Name of insurer	<input type="text"/>	Policy name	<input type="text"/>
Policy number	<input type="text"/>		

4. Do you consider anyone to blame for the incident?
If yes, please provide details. Yes No

It is a condition of the policy and your responsibility to provide sufficient documentation to support your loss. Failure to provide the required documentation, including the details of any other insurances, may delay and may invalidate the claim.

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PREVIOUS CLAIMS

Have you ever made any previous travel insurance claims? If "Yes", please supply details below:	<input type="checkbox"/> Yes	<input type="checkbox"/> No
<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		

CLAIMANTS DECLARATION AND SIGNATURE

1. I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement.
2. To the best of my knowledge and belief I have not omitted any material information which would affect the insurers assessment of this claim.
3. I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that Mayday Travel Claims will not accept any liability if any payments are not distributed proportionately to the persons concerned.
4. I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to Mayday Travel Claims. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act 1988 (AMRA) or other similar legislation.
5. I am aware that an insurance claim made in the knowledge that any element thereof is fraudulent is a criminal offence and that this will invalidate the policy and will render me liable to prosecution.
6. I am, by this notice, aware that Mayday Travel Claims will retain a computerised record of this claim and that they may release certain information to other insurers or other interested parties. Mayday Travel Claims maintain all data in accordance with the provisions of the Data Protection Act, 1984.

I HAVE READ AND UNDERSTOOD THE DECLARATION ABOVE AND INCLUDE THE NECESSARY DOCUMENTS TO SUBSTANTIATE MY CLAIM

Claimant(s) full name(s)	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Claimant's signature	<div style="border: 1px solid black; width: 280px; height: 40px;"></div>	Date	<div style="border: 1px solid black; width: 100px; height: 20px; text-align: center; font-size: small;">DD/MM/YYYY</div>
		Would you like a third party to act on your behalf?	<input type="checkbox"/> Yes <input type="checkbox"/> No
I / we authorise	<div style="border: 1px solid black; width: 470px; height: 20px;"></div>		to act on my behalf in this matter.

THIRD PARTY DETAILS (if applicable)

Name	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
Address	<div style="border: 1px solid black; height: 20px; width: 100%;"></div>		
		Post code	<div style="border: 1px solid black; width: 100px; height: 20px;"></div>
Date of birth	<div style="border: 1px solid black; width: 280px; height: 20px; text-align: center; font-size: small;">DD/MM/YYYY</div>	Relationship to claimant	<div style="border: 1px solid black; width: 280px; height: 20px;"></div>
Telephone	<div style="border: 1px solid black; width: 280px; height: 20px;"></div>		