

# MEDICAL & OTHER EXPENSES CLAIM FORM

Claim Number:



## Claims Settlement Agencies Limited

308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD  
Tel: 01702 427172 Fax: 01702 427173  
email: info@csal.co.uk www.csal.co.uk

Please use the address to the left 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:

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

# MEDICAL & OTHER EXPENSES CLAIM FORM

Claim Number:

## 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 agent who issued the policy:			
Q10. Travel Insurance Policy Number (as shown on your insurance schedule):			
Q11. Policy issue Date ( <b>very important</b> ): / /			
Q12. Method of payment for the holiday (Delete as necessary): 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? <b>YES / NO</b> 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? <b>YES / NO</b> If 'YES' please provide a copy of any report obtained			
Q18. Were you admitted to hospital? <b>YES / NO</b> 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? <b>Please complete the CLAIM EXPENSES SCHEDULE on the next page</b>			

## 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? <b>YES / NO</b> If you obtained the form, and still have it in your possession, please forward it to us:			
Form obtained: <b>YES / NO</b>		Form attached: <b>YES / NO</b> (delete as applicable)	
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 <b>YES / NO</b> 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? <b>YES / NO</b>			Their ref (if known):
Q24. Was the injury or illness caused by another party? <b>YES / NO</b> 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? <b>YES / NO</b> If 'YES' please provide details and the name, address and reference of any company handling the matter on your behalf:			
			Reference:

# MEDICAL & OTHER EXPENSES CLAIM FORM

Claim Number:

## PREVIOUS CLAIMS

**Q26.** Have you or any other person named on this form ever made any previous claim for loss of or damage to personal effects against 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
<b>TOTALS:</b>					

## 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):

<b>Q28.</b> Currency Used:	<b>Q29.</b> 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:

## DATA PROTECTION NOTICE

Claims Settlement Agencies Ltd may use your information together with other information for underwriting, statistical analysis and claims. We may disclose your information to our service providers, agents and business partners for these purposes.

We may also share your information with other interested parties and outside agencies to check the details and prevent fraudulent claims. We may also disclose your information to our agents to investigate or prevent fraud.

# MEDICAL & OTHER EXPENSES CLAIM FORM

Claim Number:

## 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

### 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? **YES / NO**

Name of company:

Policy Number:

### SETTLEMENT DETAILS

Claims payments made by BACS transfer or other electronic banking system can be made and credited to your account more quickly than a cheque.

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:

If you require payment by cheque, to whom should the settlement be made?

**Please note if the bank details provided are illegible or we are unable to validate, payment will be made by cheque payable to the claimant and posted to the address provided.**

### 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: