Travel & Wintersports Insurance
Claim Form

Part A
EMERGENCY MEDICAL EXPENSES
Part B
HOSPITAL BENEFIT

Resort Staff
Esprit

If you are sick or have suffered an injury please refer to your Resort Manager before completing this form.

Please fully complete this form and once done hand to Resort/Hotel Manager for counter signature and then send it with all supporting documents (documents may be sent on at a later date if necessary) to Claims Settlement Agencies, 308-314 London Road, Hadleigh, Essex, SS7 2DD and they will deal direct with you. It will usually take about a week to 10 days for a claim to be processed.

Please note:-

- **Completing and sending this form is solely your responsibility, do not expect your manager to do it.**
- **Please return this completed form within 31 days of incident. Late claims maybe repudiated**

The section below details the documents which you should enclose in order for us to deal with your claim. They must be **originals not photocopies** (other than for death). Please tick yes if enclosed and no if not.

		Yes	No
a)	Medical evidence to support details of illness or injury.	☐	☐
b)	Original receipts for costs incurred.	☐	☐
c)	If the claimant was a hospital in-patient, evidence to show admission and discharge dates.	☐	☐
d)	DSS form, if you travelled to an EEA country (see notes below)	☐	☐
e)	Any accident report form or police report if applicable.	☐	☐
f)	If claiming for medication in France the Feuille de Soins must be signed by you on the reverse	☐	☐
g)	In cases of death, a photocopy of the death certificate.	☐	☐

CLAIM FORM NOTES – Please read before completing this form

1) Travellers from the UK, who are eligible, are entitled to free or reduced-costs for emergency medical treatment in the other EEA (European Economic Area) countries.

2) If you are in possession of an EHIC (European Health Insurance Card), please **do not** send this to us, only the DSS Form completed (whether you have an EHIC or not). Failure to do so may delay the processing of your claim.

SIGNATURE

Please sign and date the form on the final page together with your resort manager.

TELECLAIMS

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

.... or ....

Failure to complete these documents above will delay the processing of your claim

PLEASE COMPLETE USING CLEAR BLOCK CAPITALS

1. Claimant's title: MR/MRS/MISS/MS

Forenames: ....

Surname: ....

2. Correspondence Address:

....

....

....

....

Post Code: ....

3. Telephone No. Home: Mobile:

Email address:

4. Occupation: Age:

5. The destination and country of your employment:

6. The policy no. (see policy for no.)

Do you have Part B: Yes/No

7. Name of your Employer:

8. The period of employment giving total number of days.

From: To:

Total no. of days:

9. Please tell us the date and resort in which the injury was sustained or the illness contracted:

Date: .... Resort: .... Country: ....

10. Does the incident relate to an illness? Yes ☐ No ☐ If yes, please provide a full description:

....

....

11. Does the incident relate to an injury? Yes ☐ No ☐ 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) Were you : Snowboarding Yes ☐ No ☐

Skiing Yes ☐ No ☐

Other Yes ☐ No ☐

Please describe ....

....

d) Were you off piste? Yes ☐ No ☐

e) Do you consider anyone to blame for the accident? Yes ☐ No ☐

If yes i) Please provide name, address etc ....

ii) Please show the reasons you believe this person(s) is to blame ....

....

12. Does your claim involve a medical condition for which previous medical advice/treatment has been given? Yes ☐ No ☐

If yes, was this condition declared? Yes ☐ No ☐

If yes, please quote your reference number ....

13. Was the medical assistance company contacted? Yes ☐

If yes, what assistance was provided? No ☐

Reference if known: ....

14. If you were admitted to hospital, please advise:

Name of hospital: ....

Date admitted: ....

Date discharged: ....

Total number of full days as in-patient: ....

Claims for hospital benefit are covered under Part B.

15. By what method of transport did you return to the UK?

Date returned: ....

Method of transport: .... (Please provide original travel tickets)

16. Are you a member of a private medical health scheme such as BUPA, PPP or other similar organisation? Yes ☐ No ☐

If yes, please supply the name of the organisation, address and membership/group number.

Name of organisation: ....

Address: ....

....

Membership/Group No. ....

17. Do you have any other insurance which may cover this incident (eg Bank Account holder)? Yes ☐ No ☐

If yes, please supply details of the policy(ies) ……………………………………………………………………………………………………

18.

MEDICAL AND RELATED EXPENSES

Please attach original documents and invoices, photocopies will not be acceptable.

Type of expenses (eg doctors fee, prescription, additional travel costs etc)	Name of provider (doctor, hospital etc)	Currency used and amount	Please indicate whether the bills are paid or unpaid (✓)		OFFICE USE ONLY
			UNPAID	PAID	
	TOTAL				

OFFICE USE ONLY	DATE EX RATE	GROSS £	X/S £ TOTAL £	NETT £

20. Are there any other costs outstanding or expected (not listed above)? Yes ☐ No ☐

If yes, please list below showing estimated amounts

………

………

………

And Finally…..

To finalise your claim please sign the declaration below, however before doing so please read the following carefully:-

- Please study the policy wording and read the terms and conditions that relate to your claim
- You are responsible for the cost of obtaining any documentation in support of your claim
- This Insurance contains rights of subrogation and I confirm I assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever necessary to secure such rights.
- Information on this form will be used by insurers to deal with any claim. Insurers 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 declare that, to the best of my knowledge and belief, all information stated herein is correct and that the insurance company is subrogated with all rights I may have against any third party(s).

I consent to Claims Settlement Agencies seeking reimbursement of medical expenses from The Pensions Service and any relevant authority arising out of medical treatment received.

I have not withheld any information from insurers within my knowledge connected with my claim.

I agree to provide further information or documentation that may be reasonably required.

SIGNATURE OF CLAIMANT: .... DATE: ....

SIGNATURE OF EMPLOYER*****: …………………………………… DATE: ………………………………..

Warning

Making a fraudulent or knowingly exaggerated claim is a criminal offence and could render the offender liable to prosecution.

Copy

Please take a copy of this claim form and any attachments for your records and send the original with all supporting documents to Claims Settlement Agencies, 308-314 London Road, Hadleigh, Essex, SS7 2DD

*** Note to Manager/Employer**

Please hand back to member of staff to send, it is their responsibility.

DSS Consent Form

Department of Social Security
Pensions and Overseas Benefits Directorate
Tyneview Park
Whitley Road
Newcastle upon Tyne
NE98 1BA

Claim Ref:

Date:

I hereby consent to Claims Settlement Agencies Ltd seeking reimbursement of medical expenses paid by them on behalf of Insurers arising out of medical treatment received in ____________________ on ____/_____/2009 from various medical sources.

Signature: …………………………….Date……………………………

Full Name of Patient…………………..………………………………..

Date of Birth of patient:………………………………………………..

National Insurance Number…………………………………………….

National Health Service Number……………………………………….

European Health Insurance Card (EHIC) Number……………………..

Nationality…………………………………………………………………

If patient is under 16 years of age:

Full name of parent/guardian……………………………………………

Date of birth of parent/guardian…………………………………………

National Insurance Number……………………………………………..

National Health Service Number……………………………………….

European Health Insurance Card (EHIC) Number……………………..

Nationality…………………………………………………………………