Medical & Curtailment Claim Form

Please complete all relevant sections of this Claim Form and return to:
P J Hayman Claims Department, Stansted House, Rowlands Castle, Hampshire PO9 6DX
Email: claims@pjhayman.com

Claim Number | | | | | | | | | | **(for office use only)**

If you require a large print version, please call **02392 419 020**
Please use **BLOCK CAPITALS** when filling in your form. If there is insufficient space for your answers please, use the Additional Information sheet on page 4.

Check List of Required Documents

Please send the following to support your claim.
If you do not enclose all the documentation we have listed any settlement of your claim will be delayed.
Tick ✓against documentation enclosed.

- ☐ Insurance Schedule (if you have an Annual Insurance a copy would be sufficient).
- ☐ Medical Pre-screening Confirmation (if applicable).
- ☐ Holiday Booking invoice showing the date the holiday/trip was booked, who was booked to travel, travel dates, destination, amounts paid and purchase of your travel insurance (if applicable).
- ☐ All Medical Receipts and Invoices (French medical accounts should be signed by you in the 'signature de l'assuré' box before submitting them). We are unable to accept costs which are not supported by proof of payment.
- ☐ A Medical report from the treating doctor.
- ☐ The Pension Service Form (where enclosed).
- ☐ The Medical Certificate completed by the usual treating GP of the person causing the claim (where enclosed).

FOR SKI PACK CLAIMS ONLY (the following additional information is required)

- ☐ Written Confirmation from the treating doctor that you were unable to use the remain proportion of your ski pack.
- ☐ Original Receipts/Invoices for the Ski Pack items showing how many days they were booked for and the amount paid.

FOR CURTAILMENT CLAIMS ONLY (the following additional information is required)

- ☐ The Medical Certificate completed by the usual treating GP of the person causing the claim (where enclosed).
- ☐ The Tour Operator's report into the incident which caused the curtailment (where available).
- ☐ Any flight tickets/boarding passes etc. which confirms the return home journey.

Please Note - scan & photocopies are acceptable, however, we do always encourage you to retain the original documentation in case we require any particular documents to be sent in for inspection or retention. Examples where this would be required are high value claims (for prevention of fraud) where we are required to retain originals for a certain period of time.

Claimant/Contact Details:

Claimant Name: | Claimant Age:

Name of Person handling the claim: (if different to above)

Address for Correspondence:

Postcode: | Tel No:

Email address:

Planned Travel Dates:

Outward Journey Date: D D M M Y Y | Return Journey Date: D D M M Y Y

Insurance Policy Details:

Name of Travel Insurance: (e.g. Travel Plus)

Travel Insurance Policy Number: | Date Insurance Purchased: D D M M Y Y

Medical Screening Reference: *Please enclose the Medical Screening Confirmation – if applicable*

Other Insurance Policies:

Do you hold **any** other insurance policy that may provide you with additional cover for your claim (e.g. BUPA, etc)? ☐ YES ☐ NO

If **yes**, please give details

Details of Claim:

Please describe the nature of the injury/illness

Date of accident/onset of illness D D M M Y Y Place of accident/illness (country)

If you are claiming because of illness - Have you previously suffered from this condition? ☐ YES ☐ NO

If **yes**, please provide details

If you are claiming because of an accident - Circumstances of accident

Were you admitted as a hospital inpatient: ☐ YES ☐ NO

If so: Date admitted / / Time admitted / / Date discharged / / Time discharged / /

Were any member of your party or family required to attend to you whilst in hospital? ☐ YES ☐ NO

How were you transported to hospital:

The approximate distance between hospital and resort:

Medical Costs - if you were treated as an inpatient or outpatient:

Were the Medical Assistance Company contacted? ☐ YES ☐ NO

If Yes, please show date & time of initial contact and their reference: Date / / Time Ref

If No, please confirm why:

MEDICAL ACCOUNTS ALREADY PAID (please attach separate list if necessary)

Bill Number (If you have more than 1 bill, please number them for ease of reference)	Description Of Bill	Date Paid	Amount Paid (and currency used)	Did you use a EHIC? (European Health Insurance Card) this may reduce your excess
1		DD MM YY		☐ YES / NO ☐
2		DD MM YY		☐ YES / NO ☐
3		DD MM YY		☐ YES / NO ☐
		TOTAL:		

OUTSTANDING MEDICAL ACCOUNTS STILL AWAITING PAYMENT (please attach separate list if necessary)

Bill Number	Description Of Bill	Invoice Amount (in local currency)
1		
2		
3		
	TOTAL:	

Do you expect any further Medical Invoices? ☐ Yes ☐ No ☐ Don't Know

Will the Insurance Company be invoiced direct for any medical treatment? ☐ Yes ☐ No ☐ Don't Know

If Yes / Don't Know to either of the above, please provide details

ADDITIONAL RETURN HOME / TRANSPORT COSTS (if applicable)

Expenses Incurred	Description of Expenses (e.g. Taxi cost from Apartment to Airport)	Amount Paid
Flight Costs		
Taxi Costs		
Other		
	TOTAL:	

SKI PACK COSTS (if applicable)

	Period you were unable to use your Ski Pack (Please show full days only)				Total Amount Paid
Ski Pass	From:	DD MM YY	To:	DD MM YY	
Ski / Equipment Hire	From:	DD MM YY	To:	DD MM YY	
Ski Lessons	From:	DD MM YY	To:	DD MM YY	

Curtailment Claims Only (only complete the following section if you had to curtail your holiday / trip)

Date you were advised to curtail your trip: D D M M Y Y

Who advised that curtailment of your trip was necessary?

Names of people claiming under this insurance:

1. | 2. | 3.

4. | 5. | 6.

Curtailment due to Medical Reasons:

Description of injury/illness causing Curtailment:

Name of Person causing the Curtailment:

Your relationship to them:

PJ Hayman & Company Limited may need to contact the GP who has completed the medical certificate, should further clarification be required. Please confirm that this is in order by providing the patient's signature below.

Signature Of Patient:

Name of GP:

Address of GP:

Curtailment due to Other Reasons:

Please state reason

- If curtailment is due to any other reason, we may request additional independent confirmation of the need to curtail.

Cost of the Holiday/Trip:

Total Amount Paid (less insurance premium) £

Date Paid D D M M Y Y

Amount Refunded (if any) £

Total Amount Claimed (proportionate cost) £

Settlement Method - Claims are paid by Cheque or Bank Transfer

Where a majority of our insurers will use Bank Transfer, please complete the below to prevent us asking for this at a later date:

Bank Name/Address

Sort Code

Name on Account

Account number

Declaration - I declare that to the best of my knowledge and belief all information provided is correct. I understand that some of the information I have provided will be made available to other insurers for claims handling purposes. I consent to the seeking of information from other insurers to check the answers I have provided and I authorise the giving of such information. I agree that I will supply all requested, necessary documents in support of my claim at my expense.

Signature: Date: D D M M Y Y

Additional Information: