TRAVEL (MEDICAL EXPENSES) CLAIM FORM

Claimant's Name: ____ Policy Number:______________

Address ____

____ Telephone number : __________________

Email address: ____

Name, address and telephone number of person handling claim, if different from above:

____

Booked travel dates : From: ___________________________ To: _____________________________

Date of accident / onset of illness : _______________ Country : ______________________________

Circumstances of accident (if applicable) : ____

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Nature of injuries / illness : ____

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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 : ____________________

Details of expenditure : ____

Nature of Expenditure	To Whom Paid	Currency & Amount	Paid/Unpaid

If bills are unpaid and direct settlement is required, please give name(s) and addresses of payee(s):

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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 :** _______________________