



International Travel Protection

# Personal Accident Claim Form

	<b>IMPORTANT</b> Please keep a separate note of this claim reference number and quote it whenever you contact us.
	Date: <input style="width: 60%;" type="text"/>
Dear <input style="width: 30%;" type="text"/>	Your Reference: <input style="width: 60%;" type="text"/>

## CLAIM FORM

Here is your claim form, as requested. Please complete it fully and return to us.

Please check that we have correctly stated your name, initial(s), address and post code and amend if necessary.

Our aim is to give you the fastest possible service but to achieve this, we need you to answer **ALL** the questions in detail and to submit documents in support of the claim.

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form. Thank you.

### VERY IMPORTANT

Please ensure you enclose the following **ORIGINAL** (not photocopied) documents (if not already sent).

- a) Proof of insurance, such as a numbered certificate or validation receipt. Yes  No
- b) Medical evidence to support details of injury. Yes  No
- c) If applicable, written confirmation from your employer that you are in permanent full-time employment. Yes  No
- d) In cases of death, a copy of the death certificate is required, coroners report, letters of administration or grant of probate detailing executors. Yes  No

### THE PURPOSE OF THE TRIP (where accident occurred)

- a) Were you on a business trip? Yes  No
- b) If yes, did your employer pay for the transportation and accommodation? Yes  No
- c) If not, was it a leisure trip? Yes  No
- d) Were you on a combined leisure and business trip? Yes  No
- e) If yes, please stipulate the dates of the leisure part of the trip. from:  to:

### TELECLAIMS

In an effort to promote a speedier service 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. If you do not have any objection to us contacting you by telephone, please advise us of any relevant numbers on which you could be reached:

Empty rounded rectangular box for office use.

1. Claimant's title (Mr./Mrs./Ms):  Forenames:

Surname:

2. Address:   
  
 Post Code

3. Daytime Tel:  Evening Tel:

E-mail:

4. Occupation:  Age:

5. Full address of employer:  Name of Contact Person:

6. a. The date of policy issue (this is important): Day:  Month:  Year:

b. The policy number and policy prefix (if relevant): Prefix:  No:

7. The name of the agent who issued the insurance:

8. The period of your trip, giving total number of days: From:  To:   
Total no of days:

9. If different to above, please advise the name, address and telephone number of the person we should correspond with:

10. Please briefly describe the nature of the injury and the extent of the disability in your own opinion:

11. Please advise whether treatment was being given for the injury or any other medical condition prior to the trip. Yes  No  If yes, please give details:

12. Have you already submitted a claim for medical expenses to us? Yes  No

If yes, please advise the claim no if different to that shown on this form:

13. Please give the names and addresses of any independent witnesses to the accident:  
1. Name:  Address:   
  
  
2. Name:  Address:

## MEDICAL CERTIFICATE

In the event of injury the Claimant must obtain, at their own expense, the following Certificate from a duly qualified and registered Medical Practitioner. This is intended to provide basic information and a full medical report may be required at a later date.

1. Claimant's name  Date of Birth:

2. When did you first attend the claimant for these injuries?

  

3. What was the cause of these injuries, to your knowledge?

  

4. What injuries were sustained?

1) Nature and extent of injuries:

2) Areas(s) of the body affected (if hand, arm, foot or leg, state whether it is right or left):

3) Are the injuries sustained:

a) due to the accident alone?

b) Attributable to any other cause?

5. Is the claimant now, or was the claimant at the time of the accident suffering from any illness or disease, irrespective of their injuries? If so, state the nature of same and to what extent this affects the extent of the recovery:

  
  
  

6. If you are the usual medical attendant of the claimant, are you aware of anything in his/her previous medical history which might have contributed directly or indirectly, to the occurrence of the accident, or which may be likely to retard in any way his/her recovery from it?

  
  

7. If the claimant has ceased to be a) totally disabled, b) partially disabled, please state from what date or dates:

  

8. It is possible that we will require a more detailed report from you. If so, please indicate whether you are in a position to assist, with the patient's permission: Yes  No

Name and Address  
of General Practitioner

  

Telephone No:

Thank you for your co-operation.

**I certify that the foregoing statements are correct**

Signature

