

Here is your Claim Form, as requested. Please complete it fully and return it to us.

Please ensure that you quote the Claim Number shown opposite on all correspondence.

CLAIM NO.

Personal details (required for all claims)

Surname _____

Forename(s) _____

Title _____ National Insurance No. _____

Date of Birth _____ Occupation _____

Telephone No. Day _____

Evening _____

Home address _____

_____ Postcode _____

E-mail _____

Policy details (required for all claims)

Policy number

Date of booking

Name of Travel Agent

 Company name
(if applicable)

Date of travel

Name of Tour Operator

Date of issue

Date of return

Destination

Claim details

Reason for curtailement _____

Names of all persons who curtailed their trip
Age
Relationship to claimant

Actual date of return

Number of unused nights

 If curtailement was due to a medical condition of your party has a medical claim been submitted? Yes No

 Was our medical emergency number contacted? Yes No

Date _____ Time _____

Claim number

Please provide us with details of ANY credit cards which YOU hold e.g. Visa Gold Card from Barclaycard

ETI – International Travel Protection Claims Service

14th Floor, Leon House
201-241 High Street
Croydon CR9 1ER, England
Tel: +44 (0) 870 2415039
Fax: +44 (0) 870 2415038
E-mail claims@travel-insurance.com

The Financial Ombudsman Service

South Quay Plaza 2
183 Marsh Wall
London E14 9SR
www.financial-ombudsman.org.uk

The Association of British Insurers

51 Gresham Street
London, EC2V 7HQ
www.abi.org.uk

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ETI is a Branch of Europaeiske Rejseforsikring A/S, a company incorporated in Denmark – www.europaeiske.dk

ETI is registered in England, Reg. Branch No. BR002862 and Company No. FC018451. www.travel-insurance.com

Particulars of claim *please continue on a separate sheet if necessary*

Nature of expenses	Provider	Cost	
		Local Currency	Sterling

Please Note – We require original travel tickets, booking invoices, boarding passes etc. to be provided.

Preliminary Medical Certificate

To be completed by the usual medical practitioner of the ill/injured person. Please continue on a separate sheet of paper if necessary.

This information will be treated as PRIVATE AND CONFIDENTIAL. PLEASE COMPLETE IN BLOCK CAPITALS

1. Patient Name	2. Patient Age
2. Are you the patient's usual Medical Practitioner?	
3. If so, for how long?	
4. a) State the date you first attended the patient for the present illness/injury. b) If for pregnancy reasons, give date confirmed and expected date of delivery.	
5. Please give a brief account, with dates of onset, course and progress of present illness/injury.	
6. Has the Patient received a terminal prognosis?	<input type="checkbox"/> Yes <input type="checkbox"/> No
7. a) Please provide dates and details of any in-patient treatment. b) Date placed on waiting list	
8. Has the patient suffered from the same or similar condition in the past? If the answer to this is YES, is the present illness, in your opinion, resulted in any way from the past condition?	
9. Has the patient been totally disabled from attending to any aspect of his/her business or occupation as a result of this condition?	
10. When did total disability cease? If continuing, when do you anticipate return to work?	

DOCTOR'S DECLARATION: I declare that I have examined the patient named above and/or have referred to their medical records and confirm that the information given above is a true and accurate statement, and further that no material information has been withheld.

Signature _____
 Print name _____
 Date signed _____

This section to be validated by surgery's stamp

Claimants declaration and signature

- 1) I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement.
- 2) To the best of my knowledge and belief I have not omitted any material information which would affect the insurers assessment of this claim.
- 3) I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that 'ETI' will not accept any liability if any

payments are not distributed proportionately to the persons concerned.

- 4) I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to 'ETI'. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act (AMRA) or other similar legislation.

I have read and understand the declarations above

Claimant(s) full name(s)

Claimant(s) signature(s) Date
 X

Full name of an authorised representative of the corporate policy holder (corporate and/or educational group cover)

Signature of authorised representative Date
 X