CLAIM No:- _____

Sedgwick, Merrion Hall, Strand Road, Sandymount, Dublin 4, Ireland.
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Tel: 00353 (0) 1 6619 133 Fax: 00353 (0) 1 6615 249

Medical - Claim Form

Sedgwick are committed to providing a quality service. In order for us to assist you as quickly and efficiently as possible, it is important that you provide all necessary documentation.

If a claim is received without the correct documentation or the claim form has not been fully completed, this can delay your claim.

IMPORTANT – Insurers require ORIGINAL documents. You must provide, at your own expense, any documents required to process your claim. **We strongly recommend that you keep copies of all documents forwarded to us.**

Documentation Required: - Failure to provide can result in our being unable to process your claim

	Please tick to confirm you have attached the following documents	[Tick]
Fully Completed Claim Form	Complete each section. Do not use N/A.	
Confirmation of Insurance	Insurance/Validation Certificate. In the case of credit card Insurance policies, please forward your credit card statement showing payment of the trip / holiday. **IMPORTANT: IF YOU ARE PROVIDING YOUR CREDIT CARD STATEMENT, PLEASE ENSURE ONLY THE FIRST 6 AND LAST 4 DIGITS OF YOUR CREDIT CARD NUMBER ARE SHOWN**	
Confirmation of Trip Dates	Tour Operators Confirmation Booking invoice. Also Forward any travel tickets you may have or any other documents as evidence of this trip.	
Receipts	Original receipts for all medical expenses.	
Medical Report	If claim is for hospital in-patient treatment abroad and the medical assistance company was not contacted or authorised the expenditure, all medical reports from the treating doctor are required	
Completed medical Certificate **(To be completed ONLY if :- You were in hospital outside the EU and the 24 hour Medical Assistance Company was not contacted or did not authorise the medical expenses)**	If the medical assistance company did not guarantee your medical expenses and your claim resulted in in-patient treatment in a hospital outside the European Union, please have the medical certificate enclosed completed by the medical practitioner.	
Any Additional Information/documentation	Any additional information or documents which you wish to enclose to substantiate your claim	

We understand that it can at times be a daunting prospect making a claim. Please help us to help you by following these guidelines.

- **Always send original documentation (We recommend you retain copies)**
- **Make sure that the claim form is fully completed, and that the information given is as clear as possible**
- **Always provide the information requested above. If for some reason, the documentation is not available, please attach a letter advising why it has not been enclosed.**

Medical - Claim Form (Continued)

Our aim is to process your claim as efficiently as possible. In order to achieve this please ensure that you fully complete the form and provide the original documents requested on the Information Sheet. **(We strongly recommend you retain copies). Please note – if the information requested is not supplied, this can hold up your claim, and we may not be able to process it.**

NB. All sections MUST be FULLY completed. (In BLOCK CAPITALS please)

Name of Policy Holder / Patient		Age	
Name of person to whom any payment should be made payable to - If different from above		Address	
What Insurance Company did you take our your Travel Insurance with?			
What Is Your Policy Called / Credit Card Type?		Post Code (If Applicable)	
Policy / Certificate Number If Credit Card Please write the Number (first 6 and last 4 digits only please)		E-Mail address	
Policy Issue Date		Incident Date	
Telephone Home		Mobile Telephone	
Country of Destination		Travel Agent	
Departure Date		Booking Date	
Original Return Date		Actual Return Date	
Tour Operator		Occupation	

We use personal information which you supply to us for administration, claims management and other insurance purposes, as further described in our Privacy Policy, available here: https://www.sedgwick.com/global-privacy-policy#european-economic-area-and-the-united-kingdom

Claimants signature and declaration

- I declare to the best of my knowledge all particulars in this form are true and accurate, with no omissions of any material information which would affect the insurers assessment of this claim
- I give permission for any medical practitioner, Police or similar authority mentioned with respect to this claim to release information regarding my records.
- I am aware that it is a criminal offence to defraud or attempt to defraud an insurer and that by doing so I may be prosecuted. I am also aware that should any element of this claim be found to be fraudulent in any way, all elements of the claim will be denied.
- I grant Sedgwick and the Insurers they represent, full rights of subrogation in respect to any payments made on my behalf. I further agree to fully co-operate with such recovery efforts that Insurers deem necessary.
- In the event of a third party claim being liable for the loss / damage, all rights of recovery pass to Sedgwick Travel Claims on settlement of this claim.

Signed | Date

Medical - Claim Form (Continued)

Sick / Injured Persons Name _____

Date Suffered _____ Full Description of Injury / Illness _____

_____

_____

Have you suffered from this illness / injury before? **YES / NO**
If YES, Please advise treatment received / medication / dates of any hospital admission (Continue on a separate sheet if necessary) _____
_____

Did you declare this pre-existing condition when you purchased / renewed your policy? **YES / NO**
If YES, provide medical health check number if applicable _____

If Hospitalised abroad provide: Admission Date & Time _____ Discharge Date & Time _____
Name & Address of Hospital / Clinic _____
_____
Treating Doctors Name _____

Please forward all medical reports you may have received. Originals are required

Did you contact the 24 hour Emergency Assistance Company as outlined in your policy document? **YES / NO**
If YES – Advise: Date_____ Time _____ Name of Person you spoke to _____
Reference Number you were given_____
If NO – Advise why not: _____

Name and address of regular G.P. _____
_____

If you suffered an Injury, give a full detailed account of the events and circumstances which led up to the injury, including locations / times and activities being carried out _____
_____
_____
_____

Do you feel as though someone else was at fault for the incident which caused the injury? **YES / NO**
If YES, please state why and who was responsible _____
_____

Are you a member of a Private Health Insurer (VHI / BUPA/ VIVAS etc.) **YES / NO**
If YES, Advise Name of Insurer _____ Policy / Membership No. _____
This section must be completed in full

Are you insured for this incident through any other insurer? **YES / NO**
If Yes, Advise name of Insurer _____ Policy / Membership No. _____
Please note Insurers have the right to recover any outlay if dual insurance is in force.
Did you use the E1 11form (EHIC) when abroad? **YES / NO**

Did you have to return early as a result of your illness / injury? **YES / NO**
If YES, please advise date & reason why _____
_____

If you did not contact the medical assistance company Please attach confirmation from the treating doctor that it was medically necessary for you to curtail your trip. Please state expenses on the expenditure table below.

Did you have to remain longer abroad and miss your planned departure as a result of your injury / illness? YES / NO
If YES, please advise why and state the expenses on the expenditure table below._____
_____

Medical - Claim Form (Continued)

Expenditure Details

Please note: Food, telephone/fax charges and other miscellaneous costs are not covered.

	Date Expense Incurred	Description of Expense (e.g. Prescription)	Name of Hospital / Clinic / Treating Doctor)	Amount Claimed (State Currency)	Receipts attached? YES/NO	Have you paid the expense/ bill? YES/NO
Item 1						
Item 2						
Item 3						
Item 4						
Item 5						
Item 6						
			TOTAL AMOUNT CLAIMED			

Please ensure that all receipts are creoss referenced with the item number.
(You can write the number on the top right hand side of your receipt / invoice).

Please remember to include all ORIGINAL documentation requested on the information sheet:- (Please retain copies for your records)
Confirmation of Insurance, Booking invoice, Flight Tickets, Receipts for all medical expenses, any medical reports provided, completed medical certificate if the medical assistance company was not contacted and you were hospitalised or the costs exceed €500.00. Ensure all receipts are cross referenced with the item number.

Medical Certificate – Medical Expenses

To be completed if the 24 hour Medical Assistance Company was not contacted where insured was an in-patient in a hospital outside the European Union.

This section must be completed fully by the usual G.P. of the person whose death, injury or illness gave rise to the claim.
This form is not valid unless it bears the relevant official surgery / hospital stamp.
Please also forward any medical reports you received during your treatment abroad

Any expenses for the completion of this form are at the insured's expense.

Please complete all sections fully using **BLOCK CAPITALS**.

Claimant – please complete questions 1, 2 & 3 prior to giving to the medical practitioner.

1. Patients Name _____ 2. Booking Date_____ 3. Date of issue of insurance_____

4. Age _____ 5. Are you the patients usual Doctor? **YES / NO** How long for_____

6. **Details of the medical condition giving rise to the claim**

Diagnosis / Condition _____ Date of Diagnosis _____
Date of first attendance for this condition _____Was it medically necessary to curtail the trip_____
Did the sick person contact you immediately upon return from abroad? YES / NO _____
If YES, please advise date of consultation _____

7. Has your patient been referred to a consultant / specialist or hospital within :-
   a. 24 months of the purchase of insurance or the booking of the trip **YES / NO**
   b. 18 months of the purchase of insurance or the booking of the trip **YES / NO**
   c. 12 months of the purchase of insurance or the booking of the trip **YES / NO**
   If YES, please provide full details including dates, condition, prescribed medicines, any follow up action
   _____
   _____

8. Has your patient been placed on a waiting list, either for treatment or investigation within 12 months of the purchase of insurance or the booking of the trip? (See question 2). **YES / NO**

   If YES, please provide full details including dates of referral & Procedure and condition.
   _____
   _____

9. Has your patient suffered from or received any form of medical advice, treatment, or medication within the past 18 months for :
   Heart or circulatory related condition (e.g. hypertension, angina, stroke)
   A lung or breathing related condition
   Any form of cancer
   The particular condition (or associated condition) giving rise to this claim

   If YES, please provide full details including dates, condition, prescribed medicines, any follow up action.
   _____
   _____

10. Has your client received a terminal prognosis from a medical practitioner? **YES / NO**

    If YES, Date of prognosis _____ Date when condition or related condition first arose _____

11. If your patient is now deceased, was there any pre-existing condition that was a contributory factor to the cause of death.
    YES / NO IF YES, please elaborate_____

12. At the time the insurance was issued, would your patient have been aware of any condition or circumstance that may possibly give rise to this claim **YES / NO**

    IF YES, please give details and describe condition_____

DECLARATION

I have examined the above and/or referred to the relevant medical records and declare the details are accurate and correct and that no material facts have been omitted. **OFFICIAL OFFICE STAMP**

Signed _____ **Print Name**_____

Date _____