ACE European Group
200 Broomielaw, Glasgow G1 4RU
tel: 0845 841 0051 *fax:* 01293 597 332
international tel: +44 (0) 141 285 2999 *e-mail:* claims@ace-ina.com

Claim Form

MEDICAL EXPENSES

PLEASE USE BLACK INK AND BLOCK CAPITAL LETTERS AND ENSURE YOU SIGN THE DECLARATION ON THIS FORM.
THANK YOU FOR NOTIFYING US OF YOUR CLAIM. PLEASE COMPLETE **ALL** QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE 'N/A'

NAME OF POLICYHOLDER	CERTIFICATE/POLICY NO.
FULL NAME OF INSURED PERSON (MR/MRS/MISS/MS)	DATE OF BIRTH
FULL ADDRESS	
	POSTCODE
TELEPHONE NO. BUSINESS	TELEPHONE NO. HOME
FOR SECURITY PURPOSES PLEASE PROVIDE A PASSWORD WHICH WILL BE REQUIRED TO ACCESS YOUR CLAIM INFORMATION:	E-MAIL ADDRESS

FULL NAME OF CLAIMANTS	DATE OF BIRTH	RELATIONSHIP TO INSURED PERSON
1		
2		
3		
4		

ACCIDENT/SICKNESS DETAILS - PLEASE PROVIDE A COPY OF YOUR ORIGINAL ITINERARY/TRAVEL DOCUMENTS IF AVAILABLE

Type of Travel: BUSINESS/HOLIDAY ______ Date of Trip ______

Please give exact date and place where injured or taken ill: DATE ______ PLACE ______

Was an **E111** form used? ______

If **accident** please state fully:-

(a) Where the accident occurred: ______

(b) How the accident occurred: ______

(c) The injuries sustained: ______

If **illness** please state full details of your illness ______

Have you/the claimant ever suffered from this illness before? YES / NO

If YES please give details with relevant dates ______

PLEASE ALSO PROVIDE US WITH A LETTER FROM YOUR/THE CLAIMANTS ATTENDING DOCTOR CONFIRMING IT WAS IN ORDER FOR YOU TO TRAVEL.

Please state whether you/the claimant were in hospital YES / NO

If YES please state dates of hospitalisation: ADMITTED ______ DISCHARGED ______

Have you/the claimant previously claimed under this or a similar policy? YES / NO

If YES please give details ______

Are you/the claimant covered under any group private medical scheme ie BUPA/PPP or any similar scheme YES / NO

If YES please give name, address and reference number of the company concerned ______

Please give name and address of General Practitioner in the UK ______

PLEASE ENSURE YOU COMPLETE THE 'DETAILS OF EXPENSE' SECTION

DETAILS OF EXPENSE ALL ACCOUNTS, BILLS, RECEIPTS, MEDICAL CERTIFICATES, BOOKING INVOICES, ANY CORRESPONDANCE AND ANY OTHER DOCUMENTS RELATIVE TO THIS CLAIM SHOULD BE FORWARDED TO THE COMPANY

CLAIMANT NAME	NATURE OF EXPENSE	NAME AND ADDRESS OF DOCTOR OR HOSPITAL ATTENDED	CURRENCY BEING CLAIMED	AMOUNT £	PAID (✓)
			TOTAL £		

PAYEE'S BANK DETAILS WHEN THE CLAIM HAS BEEN APPROVED YOU MAY HAVE THE PAYMENT CREDITED DIRECT TO YOUR BANK ACCOUNT. THIS PAYMENT METHOD IS BOTH SPEEDIER AND SAFER THAN BY CHEQUE. IF YOU WOULD LIKE TO TAKE ADVANTAGE OF THIS ARRANGEMENT THEN PLEASE COMPLETE THE FOLLOWING:-

Name of your Bank/Building Society: ______________________

______________________ *Bank*

Address ______________________

____

____

______________________ Postcode ______________________

Bank Sort Code (from the top right hand corner of your cheque)

Account Number ______________________

Account Name(s) ______________________

____

DATA PROTECTION The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1988. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by ACE European Group Limited and its group companies. It may be held on computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

DECLARATION I DECLARE THAT ALL THE INFORMATION GIVEN IS TO THE BEST OF MY KNOWLEDGE AND BELIEF, FULL TRUE AND CORRECT.

______________________ ______________________

SIGNED DATE

CHECKLIST PLEASE RETURN THE COMPLETED CLAIM FORM TOGETHER WITH ANY ENCLOSURES TO YOUR INSURANCE BROKER OR TO ACE. PLEASE ENSURE...

- ☐ YOU HAVE COMPLETED ALL RELEVANT QUESTIONS ON THIS CLAIM FORM
- ☐ YOU HAVE ENCLOSED ALL REQUESTED INFORMATION/DOCUMENTATION
- ☐ YOU HAVE SIGNED THIS CLAIM FORM .

AS FAILURE TO DO SO WILL RESULT IN DELAY IN HANDLING YOUR CLAIM

Thank you for fully completing this claim form.