

# Notification Claim Form



Claim Notification Reference:

\_\_\_\_\_  
(For Office Use Only)

Your Details:

Name:

\_\_\_\_\_

Type of Claim:

\_\_\_\_\_

Date:

\_\_\_\_\_

Address:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Contact Number:

\_\_\_\_\_

Email Address:

\_\_\_\_\_

## Important information / What next?

1. Please complete the attached claim form
2. Any additional notes/comments please attach to the back of this form
3. Please list supporting documentation that will be attached to this claim form:  
(Refer to the Claims Evidence document provided when you purchased your policy).

a)

\_\_\_\_\_

b)

\_\_\_\_\_

c)

\_\_\_\_\_

d)

\_\_\_\_\_

e)

\_\_\_\_\_

f)

\_\_\_\_\_

# Notification Claim Form



4. Please post the completed claim form along with any attachments to:

ONE Claims Limited  
P.O Box 372  
Hoddesdon  
EN11 1GB  
United Kingdom

## Policy Information:

Policy Number:

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Purchased from:

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Type of Policy:

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Dates covered:

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Additional Cover:

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Medical Conditions:

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Endorsements:

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## Claimant Details:

Full Name:	Date of Birth:	Job Title:	Nationality:	Place of Birth:

# Notification Claim Form



**Travel Details:**

Date of booking the trip:

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Departure Date:

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Return Date:

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Destination Country:

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Purpose of trip:

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**What are you claiming for?:**

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Amount: **£**

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# Medical Expenses and Curtailment Claim Form



Please TICK

Illness

Injury

1. Date and time illness/ injury occurred: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ : \_\_\_\_\_

2. Country where illness or Injury occurred: \_\_\_\_\_

3. Full description/ diagnosis of illness or injury: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

4. Previous Medical History

Have you suffered from the condition that has resulted in the submission of this claim, or any related condition prior to purchasing insurance or booking your holiday or prior to travelling?

Yes  No

Please have your General Practitioner complete the attached medical certificate

5. Hospital/ clinic details where treatment was provided:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone number: (If known) \_\_\_\_\_

Name of treating doctor: (If known) \_\_\_\_\_

\_\_\_\_\_

# Medical Expenses and Curtailment Claim Form



6. If you were an inpatient please complete the following

Date of admission: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

Date of Discharge: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

Did you contact the Medical Assistance Company as stated on your policy: Yes  No

If you answer **NO**, then please provide a written explanation as to why the medical assistance company was not contacted:

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If Yes, please confirm the date of your first call: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_

Person spoken to and reference number:

Did you take your EHIC?: Yes  No

Was it presented to the doctor/hospital?: Yes  No

Do you hold any private medical insurance e.g. BUPA, PPP etc? Yes  No

If **Yes**, please confirm the provider, policy number and address of the insurer:

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# Medical Expenses and Curtailment Claim Form



**Please list Medical Expenses claimed:**

Please list expenses being claimed and treatment received	Currency and amount paid	Receipt attached	State to whom payment should be made
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	

**Curtailment- Please complete this section ONLY if you returned to your home and address earlier than scheduled:**

Reason for curtailment:

Illness       Injury       Illness/ injury or death of relative       Other

Reason for curtailment:

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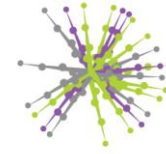


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If curtailment is due to illness/ injury or death of someone not on your policy please confirm your relationship to them:

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# Medical Expenses and Curtailment Claim Form



**one**  
here to help

Date on which you returned:

\_\_\_/\_\_\_/\_\_\_

Number of complete days unused:

\_\_\_\_\_

Were you accompanied?

Yes  No

If Yes, by whom?:

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Was the airline/train company/ ferry etc contacted to re-arrange travel dates?:

Yes  No

**Please complete the table below and list any additional expenses incurred in returning home:**

Please list expenses being claimed and treatment received	Currency and amount paid	Receipt attached	State to whom payment should be made
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	
		Yes <input type="radio"/> No <input type="radio"/>	

Do you hold any form of bank account/ credit card that offers you complimentary travel insurance that covers the circumstances surrounding your claim?

Yes  No

If **YES**, please confirm the following:

# Medical Expenses and Curtailment Claim Form



Card number:

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Issuing Bank:

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Card Type (Gold, Platinum, Standard):

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Has a claim to a third party been submitted?

Yes  No

If **YES**, please provide details:

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Is there any other relevant policy that may cover the circumstances surrounding your claim? Other policies, Barclaycard, Amex

Yes  No

If **YES**, please provide details:

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If the claim is in relation to injury please confirm the following:

1. An outline of the circumstances giving rise to the accident

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2. If a third party was involved the name and address of the Third Party and their insurance details if known

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3. In the event that you are pursuing a claim for damages against a Third Party please provide the name and address of any solicitor who may have been appointed and their reference number



# Medical Expenses and Curtailment Claim Form



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4. If no Third Party was involved please clarify who or what was at fault and why

If your claim is agreed, please provide your bank details below for payment:

Confirm payee name:

Bank Name:

Bank Address:

Bank SWIFT Code:

Bank IBAN:

Account Number:

Sort Code:

Account Holder:

Type of Account (Current, Gold, Platinum etc):

**Declaration: IMPORTANT- Failure to sign will result in your claim form being returned.**

I/we declare that the above statements are true and correct to the best of my/our knowledge and belief. I/we have not withheld any information within my/our knowledge connected with this claim. I/we agree to provide the insurer with any further information as may be reasonably required. I/we understand that the insurer does not admit liability by issue of this form. **WARNING – the making of a fraudulent or knowingly exaggerated claim is a criminal offence. We investigate all cases and any person suspected of fraud is reported to the police with whom we always co-operate.**

# Medical Expenses and Curtailment Claim Form



## DATA PROTECTION ACT

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and may be shared with other organisations for this purpose. I/we understand that you may ask for information from other organisations to check the answers I/we have provided.

## IMPORTANT

In the event of a third party being liable, all rights in this matter are subrogated to the travel insurance underwriters or their agents on all settlements of this claim.

Signature:

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Date: \_\_\_/\_\_\_/\_\_\_

# Medical Certificate



To be completed by medical practitioner Please use BLOCK LETTERS

To be obtained at your expense from the patients General Practitioner in all cases of Curtailment or Cancellation Costs resulting from injury, illness or death.

**Important:** The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries.

1. Name of the Patient: \_\_\_\_\_

Date of birth: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

2. Are you the patient's usual GP? Yes  No

If **YES**, for how long? \_\_\_\_\_

If **NO**, please provide full details of the patient's usual GP:  
\_\_\_\_\_  
\_\_\_\_\_

3a. Please give a precise diagnosis of the illness or injury or cause of death:  
\_\_\_\_\_  
\_\_\_\_\_

b. On what date did the patient first consult you with symptoms of this condition? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

4. Date of the onset of the illness or injury: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

5. Date tests prescribed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

6. Date tests carried out: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

7. Date condition diagnosed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

8. Date referred to specialist: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

# Medical Certificate



9. Name and address of specialist/surgeon:

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Postcode:

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10. Has the patient received a terminal prognosis?

Yes  No

If **YES**, please provide date and prognosis:

\_\_\_/\_\_\_/\_\_\_

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11. Have you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in question 3a?

Yes  No

If **YES**

a. State the diagnosis of the previous illness/injury

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b. Advise the date of the occurrence of the previous illness/injury and advise what treatment/ medication was prescribed

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c. Is the patient receiving any medical advice, treatment or medication for this condition or any similar/ related conditions?

Yes  No

If **YES**, please provide details:

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d. Please list all active medical conditions, date of diagnosis and details of medication, if any:

# Medical Certificate



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12. Has any other Medical Practitioner treated this patient for the same/  
similar/related illness or injury as described in question 3a? Yes  No

If **YES**, please supply the name and address of the Doctor:

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\_\_\_\_\_ Postcode \_\_\_\_\_

13. Has the patient received in patient treatment for any conditions in the  
last 24 months? Yes  No

If **YES**, please provide details of treatment and when: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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## 14. Pregnancy Only

- a. Date of LMP: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- b. Date of pregnancy confirmed: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- c. Estimate date of confinement: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_
- d. Exact medical condition within pregnancy:

- 
15. Was the claimant required to cancel the travel arrangements solely due to  
the condition described in question 3a? Yes  No

16. On which date was it recommended that the patient cancel their travel  
arrangements? \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

# Medical Certificate



17. If the dates in answer 7 and 16 differ, please provide explanation:

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18. Had the patient planned to travel against your prior advice?

Yes  No

If **YES**, please provide details:

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**I certify that the statements contained in this Medical Certificate are true and correct**

Doctor's Signature:

Date:

\_\_\_/\_\_\_/\_\_\_

Doctor's name:

Qualification:

Postal address:

Postcode:

Business phone number:

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# Medical Certificate



Fax number:

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Mobile phone number:

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Email address:

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Practice Stamp: