Insurance Administration Services Ltd

I A S Admin Dept, Po Box 9, Mansfield, NG19 7BL
telephone 01623 645308 fax 01623 632861
email claims@ias-health.com

MEDICAL EXPENSES / CURTAILMENT/ SKI PACK CLAIM FORM

IMPORTANT - PLEASE READ THE FOLLOWING CAREFULLY AND ENCLOSE THE DOCUMENTS REQUESTED

In order to process your claim quickly, please ensure that you complete any blank sections on this form with as much detail as you can as failure to do so may delay the processing of your claim. When this form has been fully completed, signed and dated, it should be **returned to the address shown above**, together with all **ORIGINAL** documentation requested.

Please ensure you read the **CHECKLIST** below and throughout this form to help you enclose the correct documents in order to avoid any delay in the processing or payment of your claim :

- ✓ Your original INSURANCE CERTIFICATE / SCHEDULE / POLICY DOCUMENT - for proof of insurance
- ✓ Your TOUR OPERATORS HOLIDAY / BOOKING INVOICE – or other documentation showing your travel dates and full cost of the trip and/or insurance
- ✓ Original MEDICAL BILLS and INVOICES must be submitted with this form to support your claim. PHOTOCOPIES WILL NOT BE ACCEPTED
- ✓ For Unused Ski Pack claims due to medical reasons - a DOCTOR'S MEDICAL CERTIFICATE from the local Medical Centre at your ski resort confirming you were unable to ski/snowboard with details of the incident/injury/illness and period you were unable to ski/snowboard
- ✓ Medical evidence must be provided to confirm the medical necessity to cut short a trip, and/or duration of your stay in hospital.
- ✓ Any other documentation requested in this form which relates to your claim – see relevant sections below.

We recommend that you keep your own copy of all documents sent to us.

You should be aware that certain information provided to us in relation to this claim will be stored electronically in accordance with current Data Protection requirements and may be shared with anti fraud and fraud prevention facilities. If you make any form of fraudulent claim or intentionally exaggerate or inflate your claim, this will invalidate your claim and this may then be reported to the appropriate authorities.

Insurance Administration Services Limited's Data Privacy Policy can be viewed at **www.ias-health.co.uk**

THE DECLARATION ON THE REVERSE OF THIS PAGE MUST BE COMPLETED

YOUR TRAVEL CLAIM REFERENCE :

Always quote the above reference when contacting this office

PLEASE SECURELY ATTACH ALL SUPPORTING DOCUMENTATION TO THIS FORM

1. Insured (Full Name)					Mr / Mrs / Miss / Master / Other
2. Occupation (of Insured)					
3. Full name of claimant (if different from above)					4. Date of Birth
5. Address					Post Code
6. Email Address					
7. Private Tel. No.				8. Business Tel. No.	
9. State the name of the person to whom payment should be made					
10. Name and Address of the Travel Agent/Tour Operator					
11. Policy / Scheme Name (found in the policy wording)					
12. Date of Trip Booking				13. Policy Issue Date	
14. Departure Date				15. Return Date	
16. Is this an Annual Policy?	YES		NO		If YES, please give the Start Date of cover (if different from Issue Date)
17. Policy Number (for Annual policy, or a Trip policy where applicable) (found on Schedule, Certificate)					
18. Country of holiday or journey destination					

YOUR TRAVEL CLAIM REFERENCE :

MEDICAL EXPENSES

1. Did you consult a doctor or have medicine prescribed prior to commencement of your holiday or journey? YES / NO
   If YES, please give details.

2. Please advise the name and address of your usual Doctor.

3. Are you claiming for these expenses under any other insurance policy? YES / NO
   If YES, please give details.

4. Are you a member of any Private Medical Plan or Scheme? YES / NO
   If YES, please advise the name and address of that Plan or Scheme. Your membership No.

5. i. Date of onset of the **illness** or **injury** for which you are claiming
   ii. Advise the nature of the **illness** or **injury**
   iii. Place where **illness** or **injury** occurred.

6. Is this claim due to an accident? YES / NO If YES, please provide a full description of exactly how the accident occurred. (Please continue on a separate sheet of paper if necessary)

7. Is this claim due to an accident involving a Third Party? YES / NO If YES, please advise who, in your opinion, you feel was responsible (Please continue on a separate sheet of paper if necessary)

WHERE NECESSARY, PLEASE CONTINUE ON A SEPARATE SHEET OF PAPER.

Date of account	Description of expense	Amount claimed (please state currency used)	Has this been paid? (yes/no)

7. Do you hold a current valid EHIC? (only applicable for trips within the EU and Switzerland) YES / NO

8. Was the policy excess paid direct to the Treating Doctor or Clinic?

9. If the excess was paid please advise to whom this was paid and the amount that was paid (Please attach the receipt)

10. Was the Medical Assistance Company shown in your policy approached? YES / NO

YOUR TRAVEL CLAIM REFERENCE :

HOSPITAL INCONVENIENCE EXPENSES

If this cover is included in your policy and you wish to make a claim, please advise the following :-

1. Date of admission to the overseas hospital.
2. Date of discharge from the overseas hospital.

✓ **Medical evidence must be provided to confirm the duration of the in-patient stay (admission and discharge dates and times)**
✓ **Forward copies of any medical reports.**

CURTAILMENT/ABANDONMENT OF JOURNEY

WHERE NECESSARY, PLEASE CONTINUE ON A SEPARATE SHEET OF PAPER.

1. Date upon which curtailment/abandonment became necessary.
2. Advise the reason for this curtailment/abandonment.

3. Please show below those persons to whom this claim relates. Please also indicate their relationship with the person causing this claim.

Name	Age	Relationship	Why curtailment/abandonment became necessary
a.			
b.			
c.			
d.			
e.			

4. If this curtailment/abandonment is as a result of an accident, please advise the following :-

(a) Date of the accident :
(b) Description of how the accident occurred :

(c) If the accident involved a Third Party eg. a Road Traffic Accident, who, in your opinion, was responsible for the accident?

(d) Name and address of the Third Party :

(e) Details of your vehicle/other insurance : (i) Insurer (ii) Policy No. (iii) Branch Address

(f) Details of Third Party insurance : (i) Insurer (ii) Policy No. (iii) Branch Address

(g) If solicitors have been appointed, please advise by whom and provide their name and address :-
Appointed by :
Name of Solicitors :
Address :

TO AVOID PAYMENT OF YOUR CLAIM BEING DELAYED PLEASE ENSURE THAT ALL DOCUMENTS REQUESTED ARE ENCLOSED AND ALL QUESTIONS HAVE BEEN ANSWERED

DECLARATION

I declare that these particulars are true and correct to the best of my knowledge.
I authorise the Insurers to approach my medical attendant for further information, should this be necessary.

Signature **Date**

Insurance Administration Services Limited
Po Box 9, Mansfield, Nottinghamshire, NG19 7BL
telephone 01623 645308 fax 01623 632861
email helpline@ias-health.com

YOUR TRAVEL CLAIM REFERENCE:

UNUSED SKI PACK

Does your claim fall under this section? YES/NO If YES, please complete the questions below.

Date of accident Country and resort.

DETAILS OF AMOUNT CLAIMED

Description	No. of days pre-paid	Cost	No. of days claimed	Refund
Lift Pass				
Ski School				
Equipment Hire				
Other*please specify beneath				

Details of injury/illness resulting in this claim.

YOU MUST INCLUDE

1. **A medical certificate from the attending Doctor confirming the period the claimant was unable to ski.**
2. **The original lift pass, ski school pass, receipt for hired equipment and any other receipts for the costs claimed.**

TO AVOID PAYMENT OF YOUR CLAIM BEING DELAYED PLEASE ENSURE THAT ALL DOCUMENTS REQUESTED ARE ENCLOSED AND ALL QUESTIONS HAVE BEEN ANSWERED

DECLARATION

I declare that these particulars are true and correct to the best of my knowledge.
I authorise the Insurers to approach my medical attendant for further information, should this be necessary.

Signature **Date**

YOUR TRAVEL CLAIM REFERENCE :

Insurance Administration Services Ltd

I A S Admin Dept, Po Box 9, Mansfield, NG19 7BL
Telephone: 0845 1300366 Fax: 01623 632861
Email: claims@ias-health.com

SETTLEMENT BY BACS

For your convenience and to offer an efficient smoother service, we would like to pay any claim settlement due directly into your bank account. Please provide ALL your details on this form as requested below, remembering to sign and date also.

If you do not wish to provide your bank details, any settlement due on your claim will be issued by cheque and may take a little longer to process.

You will receive an email from us to confirm when this payment has been made.

YOUR DETAILS	
Name of Claimant	
Email Address Where we will send confirmation of payment	

BANK ACCOUNT DETAILS	
Name of Payee This should be the same as held on the bank account	
Bank Name	
Bank Address **Country** **Post Code**	
Bank Account Number	
Sort Code	- -

If your bank account is held abroad, please also enter the following details:

IBAN / BIC number	
Swift Code	

Signed		**Dated**	

IMPORTANT : We do not accept liability for any errors due to the incorrect bank details being provided by you.

PLEASE CHECK ALL DETAILS PRIOR TO SUBMITTING YOUR CLAIM.