Fogg Travel Insurance Services Limited

Crow Hill Drive, Mansfield, Nottinghamshire, NG19 7AE
telephone 01623 631331 fax 01623 420450
email claims@foggtravelinsurance.com

MEDICAL EXPENSES CLAIM FORM

IMPORTANT - PLEASE READ THE FOLLOWING CAREFULLY AND ENCLOSE THE DOCUMENTS REQUESTED WITH THIS FORM

Please ensure that you complete any blank sections on this form 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.
In order to avoid any delay in payment of your claim you should ensure that the following documents are enclosed :-

1. Your original Travel Agents premium receipt and/or insurance certificate/policy document as confirmation that you purchased insurance.
2. Your Tour Operators holiday invoice, cancellation invoice any other documentation requested in this form which relates to your claim.
3. If your claim is for Medical Expenses, the original medical bills and invoices must be submitted with this form to support your claim. Photocopies will not be accepted. If your claim relates to your inability to ski due to medical reasons, you must provide a medical certificate completed by a doctor from the local Medical Centre at your ski resort giving details of the incident and period you were unable to ski.

The Insurance industry operates a number of anti-fraud initiatives which include TCEWS, operated by J S Management Ltd., and CUE, operated by Insurance Database Services Ltd. Details on these organisations can be provided on request.
Information given on this form may be stored electronically and shared with these organisations for this purpose. If you would prefer that the information given on this form is not used you should advise us.

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/Mast/Other
2. Occupation (of Insured)					
3. Full name of claimant (if different from above)					4. Date of Birth
5. Address (full including post code)					
	Email:				
6. Private Tel. No.					7. Business Tel. No.
8. State the name of the person to whom payment should be made					
9. Name and Address of the Travel Agent/Tour Operator					
10. Is this an Annual Policy?	YES		NO		If YES please state the policy No.
11. Date of Booking					12. Policy issue date
13. Departure date					14. Return date
15. 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. Date of onset of the illness or injury for which you are claiming
   Advise the nature of the illness or injury.
   Place where illness or injury occurred.

6. 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 and a description of exactly how the accident occurred. (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 THAT IN-PATIENT STAY

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 involving a Third Party eg. a Road Traffic Accident, please advise the following :-

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

(c) 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**