

# GLOBAL TRAVEL INSURANCE

GTI Services Limited

Amelia House  
Crescent Road  
WORTHING  
West Sussex  
BN11 1RP

Telephone: 01903 203933 Facsimile: 01903 211106 Email: [enquiries@globaltravelinsurance.co.uk](mailto:enquiries@globaltravelinsurance.co.uk) Internet: [www.globaltravelinsurance.co.uk](http://www.globaltravelinsurance.co.uk)

## TRAVEL INSURANCE CLAIM FORM

THE ISSUE OF THIS CLAIM FORM DOES NOT CONSTITUTE AN ADMISSION OF LIABILITY

**IT IS ESSENTIAL THAT ALL QUESTIONS ARE ANSWERED AND ALL REQUIRED DOCUMENTS ARE ENCLOSED TO ENABLE US TO DEAL WITH YOUR CLAIM**

FAILURE TO DO SO WILL DELAY SETTLEMENT AND MAY PREJUDICE YOUR CLAIM THEREFORE PLEASE CHECK THAT YOU HAVE ANSWERED ALL THE QUESTIONS BELOW AND THE RELEVANT SECTIONS OVERLEAF BEFORE SIGNING THIS PAGE.

### BLOCK CAPITALS PLEASE

SURNAME \_\_\_\_\_ INITIAL(S) \_\_\_\_\_ TITLE \_\_\_\_\_ AGE \_\_\_\_ DATE OF BIRTH \_\_\_\_\_

ADDRESS \_\_\_\_\_

TEL NO \_\_\_\_\_ OCCUPATION \_\_\_\_\_

NAME AND ADDRESS OF PERSON HANDLING CLAIM (IF DIFFERENT FROM ABOVE)

TOUR OPERATOR \_\_\_\_\_ COUNTRY TO BE VISITED \_\_\_\_\_ RESORT \_\_\_\_\_

DATE HOLIDAY BOOKED \_\_\_\_\_ DATE INSURANCE PURCHASED \_\_\_\_\_

DUE DEPARTURE DATE \_\_\_\_\_ DUE RETURN DATE \_\_\_\_\_

INSURANCE DOC NO \_\_\_\_\_ DATE OF INCIDENT \_\_\_\_\_

NATIONAL INSURANCE NUMBER \_\_\_\_\_ PASSPORT NUMBER \_\_\_\_\_

Are there any other insurances in force (e.g. HOUSEHOLD CONTENTS, ALL RISKS, PRIVATE MEDICAL, OTHER TRAVEL)?  
If YES, give details

**YES/NO**

Have you ever had any previous insurance losses?

**YES/NO**

Give details of any previous claims including name and address of insurers and approximate dates

### DECLARATION TO BE SIGNED BY ALL CLAIMANTS IF MORE THAN ONE

I confirm that I have taken out an Insurance with Global Travel Insurance. I declare that to the best of my knowledge and belief all information provided on this claim form and/or any attached documentation is correct. I understand that some of the information I have provided will be made available to other Insurers for claims handling purposes. I consent to the seeking of information from other Insurers to check the answers I have provided, and I authorise the giving of such information. I recognise the Company's right of subrogation in relation to any potential recovery.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**THE MAKING OF A FRAUDULENT CLAIM IS A CRIMINAL OFFENCE** Please also complete the details overleaf

### DOCUMENTATION REQUIRED

**Enclosed** Tick Box

1. Proof of insurance. The original numbered certificate of insurance and the Tour Operator's original invoice showing the premium paid.
2. The original bills, receipts for all items claimed.
3. Medical certificates issued by treating doctor.

**MEDICAL EXPENSES, REPATRIATION ALL QUESTIONS MUST BE ANSWERED**

Name of person concerned \_\_\_\_\_ Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_

Nationality \_\_\_\_\_ National Insurance Number \_\_\_\_\_ (Parents No. if child U16)

Date of accident/ onset of illness \_\_\_\_\_ Time \_\_\_\_\_

Place of accident/ illness (country) \_\_\_\_\_ (resort) \_\_\_\_\_

Circumstances of accident (If applicable) \_\_\_\_\_

Nature of injuries/ illness \_\_\_\_\_

Name and address of Doctor/ Hospital/ Clinic attended \_\_\_\_\_ How many visits were made \_\_\_\_\_

What treatment was administered?  
(prescription, injections, minor surgery, stitches, dressings, plaster, crutches, etc.) \_\_\_\_\_

If hospitalised, name and address of hospital \_\_\_\_\_

Date admitted \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_ Date discharged \_\_\_\_/\_\_\_\_/\_\_\_\_ Time \_\_\_\_\_

How were you conveyed to hospital? HELICOPTER/ AMBULANCE/TAXI/OTHER \_\_\_\_\_

**PLEASE NOTE:** No settlement can be made if Invoice Documents are not provided for our inspection. Photocopies of documents are not acceptable. Please number each bill submitted and indicate each number in the summary below. If the bills are unpaid and direct settlement is required please give name(s) and address(es) of payee(s).

Have you used a form E111 for these payments? **YES/NO** (If yes please attach a copy of E111)

Description of Bill (e.g. Doctor fee, prescription,)	No	Full name and Address of payee where direct settlement is required	Amount in local currency	Has Bill Been Paid By You?

**ALL QUESTIONS MUST BE ANSWERED**

Are you a member of BUPA, PPP or have any other Private Medical Insurance? **YES/NO**  
IF YES give name/address/reference \_\_\_\_\_

Do you expect further Medical Invoices? **YES/NO** Will the Insurance Company be invoiced direct for any Medical Treatment? **YES/NO**  
IF YES, to either of the above, please give details \_\_\_\_\_

Was the Insurance Company's Emergency Medical Service Used? **YES/NO**  
If YES, date and time first contacted \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_ am/pm

Has the claimant previously suffered from the same illness or injury? **YES/NO**  
If, Yes please give details, with dates of treatment in the last three years \_\_\_\_\_

Please complete and sign the form below:  
I (Print Name) \_\_\_\_\_ give permission for the Company to approach my own Doctor and/or treating hospital/clinic where necessary regarding my past and present health and treatment received, only in respect of this Insurance Claim. I further consent to Global Travel Insurance seeking reimbursement of medical expenses paid by them arising out of medical treatment received.

Doctors Name \_\_\_\_\_ Address \_\_\_\_\_ Tel.No \_\_\_\_\_

Claimants Signature \_\_\_\_\_ Date \_\_\_\_\_