

GLOBAL TRAVEL INSURANCE

GTI Services Limited

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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 _____