

Travel Insurance AXA Assistance Claims Centre Services Claim Form.

PO BOX 10400,
Swords, Co Dublin.

Date Sent:

Claim Ref:

PLEASE ANSWER ALL THE QUESTIONS CONTAINED IN THIS CLAIM FORM. LEAVING ITEMS BLANK, USING TICKS, DASHES AND N/A MAY MAKE IT NECESSARY FOR US TO RETURN YOUR CLAIM FORM OR LEAD TO US ASKING FURTHER QUESTIONS THUS DELAYING THE PROCESSING OF YOUR CLAIM.

Personal Details - Required for all Claims

Claimant Details	Mr/Mrs/Miss/Ms	<input type="text"/>	Home Address	<input type="text"/>	
	Surname	<input type="text"/>		<input type="text"/>	
	Forenames	<input type="text"/>		<input type="text"/>	
	Date of Birth	<input type="text"/>	<input type="text"/>	<input type="text"/>	
	Occupation	<input type="text"/>		Postcode	<input type="text"/>
	National Ins No.	<input type="text"/>		Daytime Tel.	Evening Tel. <input type="text"/>
	Nationality	<input type="text"/>		Email	<input type="text"/>

Claimants Name	Relationship to Claimant	D.O.B
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

Policy Number	<input type="text"/>	Date of Booking Trip	<input type="text"/>
Date Issued	<input type="text"/>	Depart Date	<input type="text"/>
Declared Health Problem(s)	<input type="text"/>	Return date	<input type="text"/>
Travel Agent & Branch	<input type="text"/>	No. in Party	<input type="text"/>
Tour Operator	<input type="text"/>	Total Days	<input type="text"/>
		Country / Resort	<input type="text"/> / <input type="text"/>

It is against the law to submit a fraudulent claim. If your claim is found to be fraudulent it will be declined and the authorities informed.

For Medical Related Claims:-

I authorise any doctor, hospital or other organization or person having any records or information concerning my medical history or treatment to furnish such records or information as may be requested by AXA Assistance Claims. I understand that in executing this authorization, I waive the right for such information/records to be privileged. I am also aware that such information/records are relevant in the evaluation of my claim and that non-submission could prejudice my claim. A photocopy of this authorization shall be considered as effective and valid as the original.

Signed.....(by patient/next of kin if deceased) Dated.....

1. I hereby declare that all information, answers, and documents given in connection with this claim are true and correct to the best of my knowledge and belief. I have not omitted any material information, which would affect the underwriters' judgment of the claim. I confirm that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf. AXA Assistance Claims Ltd nor the underwriters will accept responsibility if any payments are not distributed proportionately to the persons concerned.
2. I understand that the information supplied will also be used for underwriting, and fraud prevention purposes and may include passing such details to agents or other insurers.
3. I give my authority to AXA Assistance Claims Ltd to contact my household insurers or medical insurers or other travel insurers regarding a contribution.
4. I give my authorisation for AXA Assistance Claims Ltd to contact my GP in relation to any medical condition connected with this claim, and consent to relevant information being released by my doctor.

I have read and fully understand the declarations above.

Signed.....

Dated.....

Personal Accident Claims

Give details of your claim below (continue on a separate sheet if necessary)

Documents You Need to Send Us - SEND ORIGINAL DOCUMENTS BUT KEEP COPIES FOR YOUR RECORDS

- 1. Insurance policy schedule/certificate of insurance/tour operators booking invoice showing payment of your insurance premium.
- 2. Send us a full account of the circumstances leading to the accident and the injuries sustained, including the details of any witnesses or third parties involved in the incident.
- 3. Your original holiday booking invoice.
- 4. Please provide the details of your regular general practitioner and any specialists from whom you have received treatment and your written confirmation that we may contact them for further information.

Date / place / time of incident

Circumstances of incident

Name / address of Witnesses

Name / address of Police Auth

Police ref / Incident No Please attach police report.

Name of injured/deceased person

Occupation

Name / address of employer

If disablement, will you be able to return to your usual occupation? YES NO

If NO, will you be able to undertake any occupation? YES NO

Please have the following medical certificate completed by your consultant or send us the original death certificate and the letters of administration or grant of probate.

Please confirm the nature of the injury giving rise to this claim?

Date of onset Date treatment first sought?

Is injury solely resulting from external visible and violent means? YES NO

What is your understanding of the cause or the injury?

Are there any underlying medical conditions which have contributed to the incapacity / injury? YES NO

Are the symptoms consistent with the cause? YES NO

What is the likely prognosis?

Is the patient prevented from undertaking their usual occupation? YES NO

Is the patient prevented from undertaking any occupation? YES NO

Has the patient ever been treated for something similar in the past? YES NO

Further remarks / comments.

Signed.....
(Signature of Consultant)

Date.....

Medical Certificate

AXA Assistance Claims Centre Services

Claim Ref:

PO BOX 10400,
Swords, Co Dublin.

This Certificate is to be completed by the Registered General Practitioner of the person whose illness/injury has given rise to the claim.
Please Note - Any charge made for the completion of this Medical Certificate is the responsibility of the insured and is not refundable under the Insurance Policy.

- Please answer all questions. Ticks, dashes, N/A etc will not be acceptable.
- This information will be treated as Private and Confidential.
- A Certificate not containing the specific information requested will not normally suffice.

1. Full Name of Person whose condition has given rise to the claim.

2. Date of Birth. / /

3. Are you the registered medical practitioner of the person named in 1? YES NO (a) If yes, for how long?

(b) If no, what is your involvement with this matter.

4. State precise nature of:
Medical condition/illness/injury/cause of death, that gives rise to the claim.

If injury or death caused by injury, state how this was caused.

5. Has the patient suffered from the same or a similar or related condition in the last 2 years? YES NO

6. (a) State exact date of onset as in 4. / / (b) Date first consulted. / / (c) Date of any serious deterioration, if applicable. / /

7. Please provide details of any medical conditions including those which are considered to be pre-existing or on-going which have been investigated or treated, for which medication has been prescribed, consultant or hospital referrals made, or in-patient treatment received prior to the date of issue of the insurance. Please also include details of any conditions for which treatment has been refused.

8. Has the person named in 1 above received a terminal prognosis? YES NO If yes, what date was the terminal prognosis given to:

(a) the person named in 1 above. / / (b) the claimant, if not the same person. / /

9. If claim is a result of pregnancy, please advise: (a) Date pregnancy confirmed. / / (b) LMP. / / (c) ECD. / /

10. (a) Did the person named in 1, if travelling, consult you prior to their journey as to the advisability of undertaking the holiday or journey. If yes, on what date. YES NO / /

(b) On this date did you confirm the patient was fit to travel? YES NO

11. (a) If the claim is for cancellation of travel arrangements please state exact reason for the cancellation.

(b) Please advise the date when it first became apparent that the travel arrangements should be cancelled. / /

(c) Please state the exact date you advised the need to cancel the travel arrangements. / /

12. Are you prepared to certify that, solely due to the condition described in 4 above, the claimants are compelled to cancel their travel arrangements? YES NO

To be completed by the Registered Medical Practitioner

I have examined the person named in 1 and/or referred to his/her medical records and I declare that the information given is correct and that no details relevant to the case have been omitted.

Name (Please print)..... Qualifications.....

Address

Surgery Stamp.

Signature Date.....