



c/o Abco Kovex Building
Swords Business Park
Swords
Co. Dublin
Tel: 0818 286878
0845 601 6556(NI/UK)

TRAVEL INSURANCE CLAIM FORM

WEB CLAIM

1. Personal Details – to be completed for all claims

Title	First Name	Surname	Date of Birth	Occupation

Daytime Contact Telephone No:

Address of person to whom all correspondence should be sent :

Address:

Email Address:

Name of person to whom any claim payments should be made:

Policy Details

Schedule Number:

Policy Type:

Issue Date of Policy

Excess Waiver Paid

Trip Details

Date of Booking	Country Visited
Planned Departure Date	Resort / Town Visited
Planned Return Date	Travel Agent Name
Total No of Days	Travel Agent Phone No

Previous Claims

Have any of the claimants previously made a claim under any travel insurance policy? Yes / No

If "YES" please give details below:

Insurance Co	Date of Claim	Amount of Claim	Type of Claim

Claimant Declaration

The information I/We have given is true. If any of the information I/We have given or any of the information given on my/our behalf is incorrect, I/We understand that you will be able to take away my/our rights under this policy.

I/We understand and give explicit consent that the information I/We provide, including any sensitive information such as my/our health records, will be passed to or used by Travel Claims International for my/our insurance. I/We understand that Travel Claims International will retain a computerised record of this claim and that they may release certain information to other insurers or other interested parties. Travel Claims International maintain all data in accordance with the provisions of the Data Protection Act.

Policy Holder must sign. A parent or guardian may sign on behalf of children under 16 years of age.

Name (Please Print)	Signature	Date



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EXAM FAILURE

Date of Examination:
College/University:
Examination:
Date results advised:
Result obtained (<i>Please ensure proof of resulted is advised</i>):
University website (<i>in order for us to confirm failure</i>):
PIN code (<i>in order for us to confirm failure</i>):
New Examination Date: (<i>proof required</i>)

1. Date on exam failure notified :

2. Was AXA Assistance contacted: If so, please provide reference number:

3. Cost of flight home

4. Date of new outbound flight:

5. Date of new inbound flight:

Documents you need to send to Us – Send ORIGINAL DOCUMENTS

1. Original Insurance Certificate.
2. Original Booking Invoice / Travel Tickets
3. Examination Result
4. Details of new flights .
5. Official document showing proof of examination resit.



Medical Certificate

«clm_number»

This section must be completed fully by the usual GP of the person whose death, injury or illness gave rise to the claim, whether travelling or not.

This form is not valid unless it bears the relevant surgery / hospital stamp.
Any expenses for the completion of this form are at the insured's expense.

Please complete using BLOCK CAPITALS

1. Patient's Name:	2. Date of Birth:
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2. Details of Medical Condition giving rise to the claim	
Diagnosis:	Date of Diagnosis:
Date of consultation this episode	Date on which you advised trip should be cancelled:

3. Did you contact Health Check to disclose your pre-existing medical condition? YES / NO.
If yes, please attach the endorsement to your claim.

1. Details of consultations in the 12 months prior to the issue date of the insurance (BLOCK CAPITALS)

Consultation Date	Findings on Examination	Treatment (Drugs; Investigations etc)	Additional Information (waiting list, consultations Follow-up)

5. Was the patient fit to travel at the time of booking the trip? Yes / No / Not due to travel
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6. Was the patient given a terminal prognosis at the time of booking the trip? Yes / No

7. Is the patient's illness or injury due to self-inflicted injury, alcohol, drug abuse, sexually transmitted disease, surgical procedures and medical treatment performed for cosmetic reasons, civil unrest, riot or war, psychological or any mental condition? Yes / No

If "YES" please give details:

8. Pregnancy

Date Confirmed:	EDD
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Reasons why pregnancy necessitate cancellation
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9. Doctors Details:

Doctors Name:		Date Patient joined your practice	
Address		Telephone No	
		Fax No	

I declare that I have examined the patient named above and / or have referred to their medical records and confirm that the information given is a true and accurate statement, and further that no material information has been withheld.

Doctors Signature:	Surgery / Hospital Stamp
Date:	