



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**

**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/your insurers 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



**Medical Expenses**

1. Name of person who suffered from the illness / injury

2. Date of onset of the illness / injury

3. Brief description of the illness / injury

4. Details of hospitalisation or in-patient treatment

Were you hospitalised or kept in as an in-patient?	Yes / No	
Did you contact the Assistance Company?	Yes / No	
If "Yes" what was the date of the first call to the 24 Hour Medical Emergency Service		
If "Yes" quote reference no received from the 24 hour Medical Emergency Service		
Date and time admitted to Hospital	Date	Time
Date and time discharged from Hospital	Date	Time
Total number of days detained in Hospital		

5. Private Health Care Insurance details:

Do you have Private Health Insurance e.g. VHI. BUPA?	Yes / No
If "Yes" please advise	
Insurer's Name	Policy Number
Address	

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

**Documents you need to send to Us – Send ORIGINAL DOCUMENTS**

- Original Insurance Certificate.
- Original Booking Invoice / Travel Tickets
- Confirmation from the Treating doctor of hospitalisation and / or confinement to accommodation (if applicable)
- Original receipts for expenses incurred.
- For trips to Europe, copy of E111 form, for trips to Australia, copy of Medicare Form.

1. In the table below please detail all medical expenses which you incurred and for which you are claiming:

Date Expense incurred	Description of Expense	Name of Provider i.e. Hospital / Clinic / Treating doctor etc	Non-Euro Currency Amount	Euro Amount	Have you paid for Expense Yes/No

Total Amount Claimed in Euros:

2. Exchange Rate used to convert non-Euro Currency to Euros: