MAPFRE | ASISTENCIA

22-26 Prospect Hill
Galway, Ireland
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TRAVEL INSURANCE CLAIM FORM

Claim Reference Number:
Policy Number:

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS

CLAIMANT DETAILS

NAME OF LEAD CLAIMANT: Title: ____ Forename: ________________ Surname: ___________________

Sex: M/F D.O.B. ____________ Occupation: ____

ADDRESS: ____

____ POSTCODE: ___________

TELEPHONE NO: Home ______________________ Work ______________________ Mobile_________________

LEAD POLICYHOLDER NAME: Title: ____ Forename: ________________ Surname: ___________________

Claimant's Relationship to Lead Policyholder: ____

HOLIDAY/TRIP DETAILS

Tour Operator: ________________ Travel Agent: __________________

Destination/Country: _________________________________

Date holiday booked: _____________________

Departure Date: ____________________ Return Date: _______________________

PREVIOUS CLAIM DETAILS:

Have you made an insurance claim in the past 5 years? **YES/NO**

If YES please provide details:

Date	Type Of Claim	Amount Claimed	Company

DECLARATION: Insurers and their agents share information to prevent fraud and for underwriting purposes. This document, information provided when taking out the Policy and relevant facts form the basis of your claim and may be shared or used for audit purposes. It is a criminal offence to make a fraudulent claim. We investigate all cases and any person suspected of fraud is reported to the Police/Gardai with whom we always cooperate in effecting a prosecution. I/We understand that you may seek information from other insurers to check that the information provided above is truthful and that details of this claim can be used for audit purposes. I/We understand that you may request information from medical providers abroad in relation to a claim where medical advice was sought. I/We declare that to the best of my/our knowledge and belief that all the information I/We have given is correct. I/We have not withheld any information connected with this incident and agree to provide any further information or documentation as may be required. I understand that the insurer does not admit liability by the issue of this form.

ALL PERSONS CLAIMING MUST SIGN BELOW:

Name (please print)	Signature	Date

MEDICAL EXPENSES - CLAIM DETAILS

Is this claim for: Medical Treatment: ________ Dental Treatment: ________

Date of injury/onset of illness: __________ Description of injury/illness:____________________________________

Did you make a medical declaration prior to Booking your Trip/Purchasing your Insurance: YES/NO

If 'Yes', please provide reference number: __________________

Please provide details of your usual treating GP:

Name: ________________ Address: ____

Do we have your authority to contact him/her? __________ If YES, please sign: ____________________________

Were you hospitalised abroad as a result of your injury/illness? _________

If YES: Admission Date: _________ Discharge Date: ________

Did you contact our 24-hour emergency service? _______ Date: _______ Advisor you spoke to: _______________

If NO please state the reason: ____

Have you received payment from any other source? _______

If YES, please provide details: ____

OTHER INSURANCE:

Do you have Private Medical Insurance? ________

If YES, please provide details: Company Name:________________ Policy Number: ________________Plan:____

Do you have an E111 / European Health Insurance Card? _________ If YES, please attach copy.

EXPENDITURE DETAILS:

Date Expense Incurred	Description	Foreign Currency Amount	Rate of Exchange	Bill Paid - Yes/No	Office Use Only

Payment Details (Please tick the appropriate form of payment):

Cheque:_____ Bank Transfer:______

If you wish to receive payment by bank transfer, please supply us with the following information;

(NB Payment cannot be issued by bank transfer unless all below details are provided)

Bank Name and Branch:____

Account Holder's Name:_____________________________ Account Number:______________________________

Sort code:________________ IBAN Number:__________________________ BIC/Swift code: ___________________

CHECKLIST: Please ensure you sign the declaration overleaf and enclose the following ORIGINAL documents as applicable:

All Claims:

Booking Invoice/Travel Tickets showing travel dates and flight/accommodation cost YES/NO

Certificate of Insurance (photocopy only) YES/NO

Hospital / Doctor / Pharmacist receipts/invoices for amounts claimed YES/NO

Report from your treating doctor abroad confirming condition for which treatment was sought YES/NO

Receipts for any additional expenses incurred (admissible under the policy) YES/NO

Copy of E111 / European Health Insurance Card YES/NO

Medical Inconvenience/Benefit Claims:

Letter from treating doctor abroad confirming hospitalisation dates (unless MAPFRE involved) YES/NO

MEDICAL CERTIFICATE -

To be completed by the USUAL TREATING GENERAL PRACTITIONER of the person whose illness/injury/death gives rise to the claim. Any charges incurred for the completion of this certificate are NOT refundable under the terms of the insurance policy

Name of person to whom this certificate applies: D.O.B. ______________

Are you his/her usual treating GP? _____________ If YES, for how long? ____________

At the latter of either the time the policy was issued, or the holiday was booked (please ask the claimant), were you aware of any medical condition which could give rise to a claim: ____

If YES, please outline details: ____

____

Please describe the CONDITION which gives rise to this claim:

When did the patient first consult for this condition? ______________

Has the patient been referred to a Consultant/Specialist/Hospitalised in the last 3 years?__________

If YES, please outline details including dates and condition for which he/she was referred: ____________________

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Please provide details of consultations in the 3 years prior to the inception of the insurance policy:

(NB - **Please complete this section in full as it may result in the document being returned if all details are not provided)**

Date of Consultation	Reason for Consultation	Medication Prescribed

Was the patient on a waiting list/awaiting results for any tests/treatments or consultation(s) at the time of inception of the insurance?________ If YES, please provide details: ____

Had the patient received a terminal prognosis at the time of inception of the insurance?______________________

If claim is related to Pregnancy:

Date Pregnancy confirmed: ________________ Estimated Due Date: _________________

Medical condition associated with pregnancy, which necessitates cancellation:

____

Doctor's Declaration:

I certify that the reason for this claim was due only to the medical reasons stated above and, in the case of a claim for cancellation, that cancellation was medically necessary.

Doctor's Name (please print) __________________ Doctor's Official Stamp:

Signature: ________________________

Qualifications: _____________________

Date: ______________________