

PLEASE ANSWER ALL RELEVANT QUESTIONS ON THE CLAIM FORM; LEAVING ITEMS BLANK, USING TICKS, DASHES AND N/A MAY RESULT IN US RETURNING THE CLAIM FORM AND/OR ASKING FURTHER QUESTIONS, THUS DELAYING THE PROCESSING OF YOUR CLAIM.

Claimant Details

Claim Reference (if known):

Title: (Mr/Mrs etc)	Surname:	Forename(s):	Date of Birth:
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Nationality:	Occupation:		
<input type="text"/>	<input type="text"/>		
Medicare Number:	<input type="text"/>	Parent/Guardian's Medicare Number:	<input type="text"/>
		<i>(If medical claim for a minor)</i>	
Home Address:	<input type="text"/>		
<input type="text"/>	<input type="text"/>		
State:	<input type="text"/>	Postcode:	<input type="text"/>
		Home Tel:	<input type="text"/>
		Work Tel:	<input type="text"/>
		Mobile:	<input type="text"/>
		Email:	<input type="text"/>

Policy Details

Policy Number:	<input type="text"/>	Date Issued:	<input type="text"/> / <input type="text"/> / <input type="text"/>	No. in Party:	<input type="text"/>
Independent Travel Arrangements:	Yes <input type="checkbox"/>	No <input type="checkbox"/>	<i>(If no, provide the following*):</i>		
* Travel Agent & Branch:	<input type="text"/>				
* Tour Operator:	<input type="text"/>				
Date of Booking:	<input type="text"/> / <input type="text"/> / <input type="text"/>	Departure Date:	<input type="text"/> / <input type="text"/> / <input type="text"/>	Return Date:	<input type="text"/> / <input type="text"/> / <input type="text"/>
Country:	<input type="text"/>	Resort/Town:	<input type="text"/>		
		<input type="text"/>			

It is against the law to submit a fraudulent insurance claim.

If your claim is found to be fraudulent the claim will be declined and Insurers will pursue recovery by the use of civil action.

- I/We hereby declare that all information, answers, and documents given in connection with this claim are true and correct to the best of my/our knowledge and belief. I/We 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, and I confirm that I understand that neither Europ Assistance nor the underwriters will accept responsibility if any payments are not distributed proportionately to the persons concerned.
- I/We understand that the information on this form will be passed to or used by Europ Assistance for my insurance, this includes underwriting, processing, handling claims and preventing fraud and could include passing details to agents or other Insurers.
- I/We subrogate all rights of recovery to Europ Assistance and also consent to them seeking reimbursement of any medical expenses paid by them.
For medical related claims:
- I authorise any doctor, hospital or other organisation or person having any records or information concerning my medical history or treatment to furnish such records or information as may be requested by Europ Assistance or their agents. I understand that in executing this authorisation, 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 authorisation shall be considered as effective and valid as the original.

I have read and fully understand the declarations above (ALL persons claiming must sign)

Claimants Name	Signature	Date of Birth	Date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Claimants Name	Signature	Date of Birth	Date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

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

- All claims** - Evidence of travel showing names of all claimants and dates of **BOOKED** outward and return travel (booking invoice, travel tickets, itinerary etc.).
- Travel delay claims only** - a letter from the transport company (airline, Bus Company etc.) with whom you were travelling when the delay occurred, detailing the cause and length of the delay you suffered.
- Missed departure claims only** - a letter from the relevant public transport company with whom you were travelling confirming the reason for and length of the delay; **OR**, if the claim is the result of a mechanical or electrical breakdown of a private motor vehicle, written confirmation from breakdown company or garage, together with service history of the vehicle; **OR**, if the claim is as a result of an accident, a report from the police, Highways Agency or other similar authority. **PLEASE PROVIDE WHICHEVER EVIDENCE IS APPLICABLE TO THE CLAIM.**
- Missed departure/Catastrophe claims only** - original receipts for all expenses. Please number the receipts and put the number in the column headed 'Ref No' when entering expenses below
- Catastrophe claims only** – written statement from appropriate public authority confirming the type of the disaster and how long it lasted, together with evidence of your original travel and accommodation arrangements

If you are unable to supply any of the documentation requested please provide a written explanation as to why.

Travel Delay, Missed Departure and Catastrophe:

Type of claim: Travel Delay Missed Departure Catastrophe Amount Claimed:

Travel Delay Claims:

Reason for delay:

Scheduled departure: Date: / / Time: Length of delay(hours and minutes):

Actual departure: Date: / / Time: Name of Carrier:

Missed Departure Claims:

Scheduled departure from the international departure point: Date: / / Time:

Place of scheduled departure: Time of scheduled check-in for international departure:

Departure from your home address or resort: Date: / / Time:

At what point in your journey did they delay occur/commence:

Eventual travel: Date: / / Time:

If the claim is submitted as a result of a motor vehicle accident involving a third party, please provide their details and those of their insurers below.

Third party's name: Insurer's name:

Third party's address: Insurer's address:

Policy No: Claim No:

Missed Departure/Catastrophe Claims: Please give full details of the circumstances (continue on separate sheet at the end of the form if necessary)

Please detail expense incurred belows (continue on separate sheet at the end of the form if necessary)

Ref No.	Date	Description of expense	Amount	Currency	Office use only

All Claims – Other Insurance:

Do you or anyone else claiming have any other insurance which may cover this trip.g. Travel Insurance with your bank/credit card account, tour operator/travel agent etc. Yes No If yes, please supply the following details

Company/Insurer's name and address:

Policy No: Has the claim been submitted to any other insurer, airline, carrier etc: Yes No

If yes, give details including claim reference number(continue on separate sheet at the end of the form if necessary)

