HealthCare International

TRIP TRAVEL INSURANCE PLAN CLAIM FORM

To help us deal with your claim quickly, please follow these guide lines:-

- Complete a separate claim form for each claim and for each insured person
- If you are submitting a claim following an accident or injury, please complete in full **Sections A, B & C**
- If you are submitting a claim for a non-medical incident or personal luggage loss, please complete **Sections A & D**
- If you are submitting a Personal Accident claim, please complete **Sections A & E**
- Please send this fully completed form to HCI Claims Management Limited together with ALL original bills relating to the loss. All submissions MUST be received by HCI Claims Management Limited within 60 DAYS of the date of the loss or commencement of treatment.

SECTION A : Insured Person

(*to be completed by the person insured or his/her legal representative*)

1. Full name of the insured person.

Title	First Name	Family Name

2. Date of Birth

Day	Month	Year

3. Policy Certificate

5. Sex

M	F

5. Full mailing address of insured person

	Post Code

6. Contact information

Telephone No.	Facsimile No.	E-Mail

DECLARATION & AUTHORISATION
I hereby declare that the answers detailed herein are true and complete to the best of my knowledge and belief. I hereby authorise the release of any information relevant to this claim to the insurer or to **HCI Claims Management Limited,**
as may be required to settle all eligible benefits. A photocopy of this authorisation shall be deemed as valid as the original.

Day	Month	Year

Signature of the Insured Person or his/her legal representative

SECTION B : MEDICAL INFORMATION

(*to be completed by the treating physician ONLY*)

7. Please state the date on which the patient first consulted you

Day	Month	Year

8. Please give your name, address and contact details

		Post Code
Telephone No.	Facsimile No.	E-Mail

9. Please give your diagnosis of the illness / injury sustained by the claimant

10. Will the illness / injury require further follow-up treatment ? If YES, please give details.

11. Please give a brief history of this or any other related condition with dates on which any previous treatment took place.

Date	Nature of condition

12. Have you any reason to believe that treatment for the same condition has been given previously ? If YES, please give details.

SECTION C : ACCIDENT and/or INJURY claims information
(to be completed by the insured person or his/her legal representative)

13. Please state nature of accident or injury

14. Please state the date on which injury or symptoms first occurred

Day	Month	Year

15. If the cause of the illness or injury relates to an accident, please state the date of the accident, location and give brief details of the circumstances and injuries received

16. Please give details of ALL other Health Insurance policies including policy number(s) that you may have.

17. Please give the name, address and telephone/facsimile numbers of the claimant's personal / family physician / doctor

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18. Is this a continuation of previous or current course of treatment for which you have already claimed under this policy ? If YES, please give further details.

19. Please list below the expenses for which reimbursement is being claimed

Date of Treatment	List of Expenses	Currency & Amount Paid	To whom you wish settlement to be made

Unless we are advised otherwise, settlement of your claim will be made in US-$ Dollars

SECTION D : NON-MEDICAL claims information

(to be completed by the insured person or his/her legal representative)

20. Please state nature of the loss, how it occurred and what action was taken to try to prevent the loss occurring.

IMPORTANT : In the event of a personal baggage loss, all incidents MUST be reported to the local POLICE within 24 hours and from whom an incident number and loss report must be obtained and submitted to HCI Claims Management Ltd.

21. Please state the date on which the loss occurred.

Day	Month	Year

22. If the loss relates to an accident, please state the date of the accident, location and give brief details of the circumstances and any injuries received

23. Please give details of ALL other Health Insurance policies including policy number(s) that may be in force

24. Please give the name, address and telephone/facsimile numbers of any witnesses to the loss

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25. Please list below the items for which reimbursement is being claimed

Description of Item	Original Purchase Date	Estimated Current Value	Currency & Amount Paid

Unless we are advised otherwise, settlement of your claim will be made in US-$ Dollars

SECTION E : Personal Accident
(to be completed by the insured person or his/her legal representative)

26. Please state the date on which the insured sustained injured or in the event of a fatality, when death occurred.

Day	Month	Year

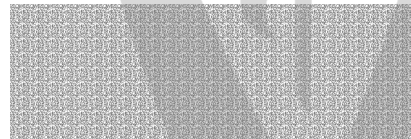
27. Please give the insured person's name, address and contact telephone number

Telephone No.	Facsimile No.	E-Mail

28. Please detail the nature of the loss or how death occurred.

29. Was the injury or cause of death as a result of natural causes ? Please describe below

In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to HCI Claims Management Limited.



Signature of treating physician

Day	Month	Year

Please return this form with all original supporting documentation including original bills / invoices and a copy of the policy document to: -

HCI Claims Management Limited
U K Administration Office
84 Brook Street
London W1K 5EH
United Kingdom

Fax : + 44 (0) 207 665 1628
e-mail : claims@healthcareinternational.com