



EMERGENCY MEDICAL EXPENSES
HOSPITAL INCONVENIENCE BENEFIT



PO Box 420
Hadlow
Kent
TN9 9DE

tel: 08453 707 133
fax: 0870 620 5001
web: www.tif-plc.co.uk

We are sorry to learn that you need to make a claim on your travel insurance policy.

In order that we can process your claim quickly please complete all the relevant sections of the claim form in full and return it to us at the above address together with the following **ORIGINAL** documentation. In the interest of protecting ourselves from fraud we are unable to accept photocopied documents however we can return your originals promptly if you indicate that this is your wish.

CHECKLIST OF DOCUMENTS REQUIRED



tick the box to indicate to us which ones we should expect to find enclosed

- BOOKING INVOICE (where appropriate)
- PROOF OF PURCHASE OF INSURANCE (either certificate or premium receipt)
- ALL MEDICAL OR PHARMACUETICAL BILLS/RECIEPTS
- PHOTOCOPY OF PRIVATE HEALTH INSURANCE/VHI SCHEDULE
- YOUR EHIC CARD IF TRAVEL WAS TO AN EU MEMBER STATE

If you have disclosed any pre existing medical conditions to the insurance company

- ENDORSEMENT CONFIRMING THAT YOU HAVE PURCHASED THIS ADDITIONAL COVER
- PROOF THAT YOU HAVE PAID ANY ADDITIONAL PREMIUM REQUIRED

If you were confined to bed on the advice of a doctor or returned home early on medical advice

- A CERTIFICATE FROM THE ATTENDING DOCTOR CONFIRMING THE NEED TO BE CONFINED TO BED OR TO CUT SHORT YOUR TRIP

If you were admitted to hospital as an inpatient

- COPIES OF ANY MEDICAL REPORTS AVAILABLE
- CONFIRMATION OF HOSPITAL INPATIENT ADMISSION AND DISCHARGE DATES AND TIMES

You should note that all the information provided to us on this form will be stored electronically in accordance with The Data Protection Act and shared with the Insurance Industry Fraud Prevention Unit. If you make a fraudulent or intentionally exaggerated claim this will invalidate your claim and we will pursue a recovery through the civil courts in all cases.

We do understand that it may take time to collect all the documentation required but please try to submit your claim as soon as possible after the event .

Yours sincerely,

Travel Claims Facilities Plc

CLAIM FOR EMERGENCY MEDICAL EXPENSES – []

Please complete all sections of this form and then check the list of additional documents you need to send in order that we can assess your claim immediately



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DETAILS OF THE INSURED PERSON WHO WAS TREATED

Title			
Full Name			
Address			
Postcode			
D.O.B.		National Insurance No.	
Telephone Number		E-mail	

DETAILS OF THE INSURANCE POLICY

Place Purchased		Scheme of Insurance	
Telephone No.		Policy No.	
Certificate No.		Date Issued	
Dates of Trip		to:	
		Trip Destination	
Medical Screening Case No. (if applicable)		Master Policy No.	

DETAILS OF TRIP

Travel Agent/Tour Operator		Tel No.	
Date of Booking		Date Final Balance Paid	
Method of Payment (Cash/Cheque/Debit Card/Credit Card)			

MEDICAL DETAILS OF CLAIM

Please give details of the illness or injury suffered

Date: Time: Place:

Where were you treated?

What was the name of the doctor who treated you?

Was this a public or private facility? Public Private

Did you use an EHC card or take advantage of a reciprocal agreement to obtain free treatment? Yes No

Did you contact our appointed emergency assistance service (EMS) for advice? Yes No

Date of your first call Time Reference No. Given

Name of the person handling your case:

Was the treatment received related to any previous treatment you have had at home? Yes No

CLAIM FOR EMERGENCY MEDICAL EXPENSES – []
MEDICAL DETAILS OF CLAIM (continued)



travel
claims
 facilities
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If so please detail

If your treatment was necessitated by an accident, was anyone else involved and could they be held responsible for what happened? Yes No

If yes please give names and addresses and if possible telephone numbers of these people and any witnesses on a separate sheet of paper.

Do you have any private health insurance or VHI cover? Yes No

Please name the scheme and give membership number

Have you **EVER** suffered from the following medical conditions? If yes, please provide details & dates. If you require more space please continue on reverse of this sheet.

Any cardiac or circulatory condition?

Any respiratory condition? (inc. Asthma)

Any type of diabetes?

Hypertension or a stroke?

Any type of cancer?

ITEMISE YOUR CLAIM

On this page please give details as accurately as possible of the bills either to be paid by your insurance company on your behalf or those which you have already paid and are seeking a refund for. If you do not yet know the amount please list the name of the provider who will send an account directly to us as this will help us match bills to your case when they arrive. We will need original receipts for all expenses claimed including that for any policy excess you paid directly to the provider. If you paid by debit or credit card please enclose a statement showing the rate of exchange applied.

Type of Expense	Name of provider of service	Amount in local currency	Method of payment
<i>Example:</i> AMBULANCE HOSPITAL	ORLANDO AMBULANCE CO.	\$350.00 US DOLLARS	VISA DEBIT
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Total sum claimed for expenses you have paid £

Total sum claimed for inconvenience benefit and curtailment £

