Email: info@reactiveclaims.com

Reactive™ Claims
Proactive Service

MEDICAL & ASSOCIATED EXPENSES CLAIM CHECKLIST

The attached claim form and relevant documents from the checklist below should be sent to us if you have had medical or dental treatment abroad or have had to return home earlier than planned and wish to make a claim under your travel insurance policy. This list is not exhaustive and we may ask for further evidence once we review your claim. A claim number will be notified to you once we have validated your details.

- ❑ **Proof of insurance and any medical endorsements –**
  POLICY OR CERTIFICATE OF TRAVEL INSURANCE / VALIDATION CERTIFICATE - your claim will be delayed if you do not submit this. (Please note this is NOT the ATOL certificate) We do not need the policy booklet.
  Employer's details and policy number where you are insured under a company scheme, insurance reference number etc.
- ❑ **Proof of travel –**
  This must show total cost of the trip, the names of all passengers, the date of booking and the travel dates and come from the tour operator or airline. If you booked independent arrangements (i.e. car hire, travel tickets, accommodation etc.) please send the booking invoice for each item
  If you booked your trip over the internet please ALSO send copies of the confirmation emails you received
  If you booked your trip through a travel agent please ALSO send copies of the agents booking confirmation
- ❑ **Unused tickets –**
  Tickets and invoices relating to any unused pre booked excursion, theme park entrance, activity, ski pass, theatre tickets etc. for which you are claiming
- ❑ **Evidence to support the claim –**
  Medical/dental receipts itemising the treatment/prescription and associated costs
  Medical/dental reports detailing the condition and treatment provided
  Written evidence from the treating doctor of the medical requirement to either extend the stay or return home early
  Proof of admission and discharge date and time if you were treated as an in-patient
- ❑ **Additional travel and accommodation costs –**
  Hotel/accommodation invoice showing dates, costs and names of guests
  Travel tickets / invoice showing date, cost and passenger names
- ❑ **Third party responsibility –**
  Name, address and general information about the person or company whom you feel was responsible for your illness or injury
  Photographic evidence should be provided if available
  Police report if applicable
  Details of any solicitor or company you have appointed to handle a personal injury claim on your behalf
- ❑ **Death –**
  Death certificate or certified copy
  Grant of Probate or Letters of Administration if the deceased is the claimant
- ❑ **Other insurance –**
  If you have submitted a claim connected to this one to another insurance company please send copies of all correspondence

To help you with your claim our FAQs can be viewed at www.reactiveclaims.com

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MEDICAL & ASSOCIATED EXPENSES CLAIM FORM

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Please answer **ALL** questions using **BLOCK CAPITALS**

Please note that ALL persons claiming under this insurance MUST be listed on the General Details page if we are to consider their claim.

1. Patients full name	**2.** Date of birth: / /	**3.** Age: yrs.
4. Nature of illness / injury / dental treatment:	**5.** National Insurance No:	
	6. Date of illness/injury: / / time : am/pm	

7. Precise medical diagnosis:

8. If injury, please advise full circumstances of the incident:

9. If injury, was anyone else involved and could they be held responsible? ❑ Yes ❑ No If yes, please provide details:

10. Was the treatment prescribed related to any previous treatment you had received prior to the trip? ❑ Yes ❑ No If yes, please provide details:

11. Have you an on-going medical condition or any medical complication directly attributable to the condition for which this claim is being made?
❑ Yes ❑ No If yes, please provide details:

12. Was this on-going medical condition being investigated / treated by a specialist GP? ❑ Yes ❑ No If yes, please provide details:

13. At the time of departing for this trip were you or anyone travelling, aware that this medical treatment would be necessary? ❑ Yes ❑ No
If yes, please provide details:

14. Health declaration – At the time of purchasing insurance, booking the trip or at the date of travel, the patient –

a) Had been given a terminal prognosis ❑ Yes ❑ No b) Was travelling against the advice of a medical practitioner ❑ Yes ❑ No

Had suffered from *(whether declared or not)* - c) Cardiac or circulatory conditions ❑ Yes ❑ No d) Respiratory conditions ❑ Yes ❑ No

e) Diabetes ❑ Yes ❑ No f) Cancer ❑ Yes ❑ No g) Hypertension ❑ Yes ❑ No h) Stroke ❑ Yes ❑ No

15. Did you contact the 24 hour emergency assistance company? ❑ Yes ❑ No Date / / time : am/pm	**16.** Please provide the 24 hour emergency assistance company reference number:

17. If applicable, did you obtain an EHIC *(European Health Insurance Card)* for your trip? ❑ Yes ❑ No	**18.** Was the EHIC presented to the hospital / doctors to offset the medical costs? ❑ Yes ❑ No	**19.** Have you personally made a claim against the EHIC? ❑ Yes ❑ No If yes, how much has been paid? £

20. Were you able to use your original booked return travel arrangements? ❑ Yes ❑ No If no, please explain why not:

21. Please provide details of new travel arrangements made:

22. Scheduled UK return date: / /	**23.** Actual UK return date: / /	**24.** Extended holiday accommodation: From: / / to: / /

25. Total **additional** accommodation costs: **£**	**26.** Total **additional** travel costs: **£**	**27.** Did you pay an additional premium for an EXCESS WAIVER? ❑ Yes ❑ No

You will need to complete a Curtailment Claim Form if you returned home to your usual place of residence earlier than planned due to medical reasons and wish to claim for a proportionate refund of the unused prepaid holiday cost.

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28. Please list all expenses being claimed whether paid by you or not. Please number the receipts and cross reference them against the expenses schedule below. *See example highlighted*

RECEIPT No.	DATE	NATURE OF EXPENSE	BILL FROM	CURRENCY	AMOUNT PAID	£ equiv.	PAID Y / N	PAYMENT METHOD
1	*01/01/2013*	*consultation*	*Dr Williams*	*US Dollars*	*$151.50*	*£100.23*	*Y*	*Visa*

29. If you have already paid the policy excess to the hospital or doctor please indicate which receipt number this refers to:	*Office use ONLY*	**30.** **TOTAL CLAIMED** **£**

If you want us to make payment of the medical costs to the suppliers direct the policy excess must be paid before we can do so. If you did not pay this in resort and the claim for your own out of pocket expenses is less than the policy excess we will request the balance from you before arranging settlement.

31. Please provide details of any further accounts to be submitted and indicate whether you require us to settle these direct with the supplier:

32. Have you or any other claimant listed made any previous claims under a travel insurance policy? ❑ Yes ❑ No If yes, please provide details:

33. Do you have any other insurance that may cover this claim e.g. BUPA, PPP, through your bank account or employer? ❑ Yes ❑ No
If yes, please provide details:

34. Has a claim been submitted to any other company in respect of this trip by any of the other party members? ❑ Yes ❑ No
If yes, please provide details:

35. Name, address and policy number of home contents insurance:

Additional information required for HOSPITAL BENEFIT claims – *for in-patient hospitalisation only*

36. Period of in-patient hospitalisation: Date admitted / / time : am/pm Date discharged / / time : am/pm	**37.** Name of hospital:	**38.** No. of days hospitalised:	**39.** **TOTAL CLAIMED** **£**

Please use this space for any additional comments: