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Travel Insurance Claim Form Information Sheet
Personal Accident

OSG Travel Claims are committed to providing a quality service. In order for us to assist you as quickly and efficiently as possible, it is important that you provide the information requested on the claim form, and on this information sheet.

If a claim is received without the correct documentation or the claim form has not been fully completed, this can delay your claim. Please therefore carefully read the notes below when completing your claim form.

IMPORTANT – Insurers require ORIGINAL documents. You must provide, at your own expense, any documents required to process your claim. **We strongly recommend that copies of all documents forwarded are made.**

Documentation Required

Failure to provide can result in our being unable to process your claim

| | Please tick to confirm you have attached the documents | [Tick] |
|--|--|--------------------------|
| Fully Completed Claim Form | Complete each section. Do not use N/A. | <input type="checkbox"/> |
| Confirmation of Insurance | Insurance/Validation Certificate. In the case of credit card Insurance policies, please forward credit card statement showing payment of the trip / holiday | <input type="checkbox"/> |
| Confirmation of Trip Dates | Tour Operators Confirmation Booking invoice. Also Forward any travel tickets you may have | <input type="checkbox"/> |
| Receipts | Receipts for all medical expenses | <input type="checkbox"/> |
| Medical Report | All medical reports provided for the incident which gave rise to the claim. If claim involved in-patient treatment abroad and the medical assistance company was not contacted, all medical reports from the treating doctor are required. Please forward a toxicology report from the hospital. | <input type="checkbox"/> |
| Police Reports & Other Authorities | Provide written police report of the incident surrounding the claim. Also please forward any death certificate / coroners / other relevant reports you may have. | <input type="checkbox"/> |
| If the claim is for total permanent disablement | Provide details of your regular medical practitioner, along with any substantiating medical reports you may have. | <input type="checkbox"/> |
| Written Account of Circumstances | Provide full, detailed, written account of the circumstances leading up to and surrounding the incident which gave rise to the claim, along with details of any witness's etc. | <input type="checkbox"/> |
| Legal confirmation of next of kin | Please provide legal confirmation of next of kin. | <input type="checkbox"/> |
| Any Additional Information/documentation | Any additional information or documents which you wish to enclose to substantiate your claim | <input type="checkbox"/> |

We understand that it can be a daunting prospect making a claim, particularly one of this nature. We will endeavour to process your claim as swiftly as possible. Please help us to help you by following these guidelines.

- Always send original documentation (We recommend you retain copies)
- Make sure that the claim form is fully completed, and that the information given is as clear as possible
- Always provide the information requested above. If for some reason, the documentation is not available, please attach a letter advising why it has not been enclosed.

Our aim is to process your claim as efficiently as possible. In order to achieve this please ensure that you fully complete the form and provide the original documents requested on the Information Sheet. (We strongly recommend you retain copies). Please note – if the information requested is not supplied, this can hold up your claim, and we may not be able to process it.

NB. All sections MUST be FULLY completed. (In BLOCK CAPITALS please)

Personal Accident Claim Form

| | | | |
|---|----------------------|---------------------------|----------------------|
| Name of Policy Holder | <input type="text"/> | Age | <input type="text"/> |
| Name of Person Claiming (and to whom any payment should be made payable to - If different from above) | <input type="text"/> | Address | <input type="text"/> |
| What Insurance Company Did You Take your Travel Insurance Out With? | <input type="text"/> | | <input type="text"/> |
| What Is Your Policy Called? | <input type="text"/> | Post Code (If Applicable) | <input type="text"/> |
| Policy / Certificate Number (If credit card, please write full credit card number) | <input type="text"/> | E-Mail address | <input type="text"/> |
| Policy Issue Date | <input type="text"/> | Loss Date | <input type="text"/> |
| Telephone Home | <input type="text"/> | Mobile Telephone | <input type="text"/> |
| Country of Destination | <input type="text"/> | Actual Return Date | <input type="text"/> |
| Departure Date | <input type="text"/> | Booking Date | <input type="text"/> |
| Original Return Date | <input type="text"/> | Travel Agent | <input type="text"/> |
| Tour Operator | <input type="text"/> | Occupation | <input type="text"/> |

Previous claims: Have you or any person named above made a claim against this or any other insurer. YES/NO

Data Protection

In order to administer your claim, the information provided in this form may be held on computer and/or in manual files for administration and risk assessment purposes. We may disclose your personal data to and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your personal data for the above purposes.

Claimants signature and declaration

- I declare to the best of my knowledge all particulars in this form are true and accurate, with no omissions of any material information which would affect the insurers assessment of this claim.
- I declare that I am the legal next of kin and have full authority to represent this claim.
- I give permission for any medical practitioner, Police or similar authority mentioned with respect to this claim to release information regarding my records.
- I am aware that it is a criminal offence to defraud or attempt to defraud an insurer and that by doing so I may be prosecuted. I am also aware that should any element of this claim be found to be fraudulent in any way, all elements of the claim will be denied.
- I grant OSG Business Solutions and the Insurers they represent, full rights of subrogation in respect to any payments made on my behalf. I further agree to fully co-operate with such recovery efforts that Insurers deem necessary.

Signed Date

Personal Accident Claim Form continued

Injured / Deceased Persons Name _____

Date Suffered _____ Description of Injury / Illness _____

Is the claim in relation to :-

Death Benefit YES / NO

Total Permanent Disablement YES / NO

Loss of Limb YES / NO

If Hospitalised abroad provide: Admission Date & Time _____ Discharge Date & Time _____
Name & Address of Hospital / Clinic _____

Treating Doctors Name _____

Please forward all medical reports you may have received. Originals are required

Did you contact the 24 hour Emergency Assistance Company as outlined in your policy document? YES / NO

If YES – Advise: Date _____ Time _____ Name of Person you spoke to _____

If NO – Advise why not: _____

Name and address of regular G.P. _____

If you / insured person suffered an Injury which resulted in this claim, give a full detailed account of the events and circumstances which led up to the injury, including locations / times and activities being carried out

Do you feel as though someone else was at fault for the incident which caused the injury? YES / NO

If YES, please state why and who was responsible _____

In the case of total permanent disablement, are you able to undertake any form of work? YES / NO

If YES, please elaborate _____

If NO, Please advise why not _____

Please attach a full Doctors report confirming this. Please note, further information may be required after assessment.

Please remember to include all ORIGINAL documentation requested on the information sheet:- (Please retain copies for your records)

Confirmation of Insurance, Booking invoice, Flight Tickets, Receipts for all medical expenses, any medical reports provided, completed medical certificate if the medical assistance company was not contacted. Ensure all receipts are cross referenced with the item number.

I declare to the best of my knowledge all particulars contained in this form are true.

In the event of a third party being liable for the loss / damage all rights in this matter are subrogated to OSG Travel Claims on settlement of the claim.

Signed _____ Date _____