



OSG Travel Claims,  
PO Box 1086, Belfast, BT1 9ES  
Email : info@osgtravelclaims.co.uk  
Tel: 020 7581 6444

## Medical - Claim Form

OSG Travel Claims are committed to providing you with a quality service. In order for us to assist you as quickly and efficiently as possible, it is important that you provide all necessary documentation.

**If a claim is received without the correct documentation or the claim form has not been fully completed, this can delay the processing of your claim.**

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

**Documentation Required: Failure to provide can result in our being unable to process your claim**

Please tick to confirm you have attached the following documents

[Tick]

<b>Fully Completed Claim Form</b>	Please complete each section. Do not use N/A.	<input type="checkbox"/>
<b>Confirmation of Insurance</b>	Insurance/Validation Certificate. In the case of credit card Insurance policies, please forward your credit card statement showing payment of the trip / holiday.	<input type="checkbox"/>
<b>Confirmation of Trip Dates</b>	Tour Operators Confirmation Booking invoice. Also Forward any travel tickets you may have or any other documents as evidence of the trip.	<input type="checkbox"/>
<b>Receipts</b>	Original receipts for all medical expenses.	<input type="checkbox"/>
<b>Medical Report</b>	If your claim is for <b>hospital in-patient treatment abroad</b> and the medical assistance company was <b>not</b> contacted or <b>did not authorise</b> the expenditure, all medical reports from the treating doctor are required.	<input type="checkbox"/>
<b>Completed Medical Certificate</b> (to be completed ONLY if ) You were in hospital outside the EU <u>and</u> the 24 hour Medical Assistance Company was not contacted, or they did not authorise the medical expenses	If the medical assistance company did not guarantee your medical expenses and your claim resulted in in-patient treatment in a hospital outside the European Union, please have the enclosed medical certificate enclosed completed by your usual medical practitioner.	<input type="checkbox"/>
<b>Any Additional information/documentation</b>	Any additional information or documents which you wish to enclose to substantiate your claim	<input type="checkbox"/>

We understand that it can, at times, be a daunting prospect when making a claim. 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.

## Medical - Claim Form (continued)

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. (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.

**N.B. All sections must be FULLY completed. (In BLOCK CAPITALS please)**

Name of Policy Holder (include Mr/Mrs/Ms. etc)	<input style="width: 95%;" type="text"/>	Age	<input style="width: 95%;" type="text"/>
Name of Person, to whom any payment should be made payable to (if different from above)	<input style="width: 95%;" type="text"/>	Address	<input style="width: 95%; height: 40px;" type="text"/>
What Insurance Company did you take out your travel insurance with?	<input style="width: 95%;" type="text"/>		
What Is Your Policy Called?	<input style="width: 95%;" type="text"/>	Post Code	<input style="width: 95%;" type="text"/>
Policy / Certificate Number (If credit card, please write full credit card number)	<input style="width: 95%;" type="text"/>	Email address	<input style="width: 95%;" type="text"/>
Policy Issue Date	<input style="width: 95%;" type="text"/>	Incident Date	<input style="width: 95%;" type="text"/>
Home Telephone Number	<input style="width: 95%;" type="text"/>	Mobile Telephone Number	<input style="width: 95%;" type="text"/>
Country of Destination	<input style="width: 95%;" type="text"/>	Travel Agent	<input style="width: 95%;" type="text"/>
Departure Date	<input style="width: 95%;" type="text"/>	Booking Date	<input style="width: 95%;" type="text"/>
Original Return Date	<input style="width: 95%;" type="text"/>	Actual Return Date	<input style="width: 95%;" type="text"/>
Tour Operator	<input style="width: 95%;" type="text"/>	Occupation	<input style="width: 95%;" type="text"/>

### 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 that all particulars in this form are true and accurate, with no omissions of any material information that would affect the Insurer's assessment of 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 liable to prosecution. 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 of any payments made on my behalf. I further agree to fully co-operate with such recovery efforts that Insurers may deem necessary.
- In the event of a third party being liable for the loss / damage, all rights of recovery pass to OSG Travel Claims, on settlement of this claim.

Signed:

Date:

## Medical - Claim Form (continued)

Sick / Injured Person's Name: \_\_\_\_\_

Date injury / illness suffered: \_\_\_\_\_ Full Description of injury / illness: \_\_\_\_\_

Have you suffered from this illness / injury before? **YES / NO**

If YES, Please advise treatment received / medication / dates of any hospital admission (continue on a separate sheet if necessary)

Did you declare this pre-existing condition when you purchased / renewed your policy? **YES / NO**

If YES, provide medical Health Check number if applicable: \_\_\_\_\_

If Hospitalised abroad, provide: Admission Date & Time \_\_\_\_\_ Discharge Date & Time \_\_\_\_\_

Name & Address of Hospital / Clinic \_\_\_\_\_

Treating Doctor's 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: \_\_\_\_\_

Reference Number you were given: \_\_\_\_\_

If NO, advise why not: \_\_\_\_\_

Name and address of your usual G.P: \_\_\_\_\_

If you suffered an Injury, give a full and detailed account of the events and circumstances that 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 that caused the injury? **YES / NO**

If YES, please state why and who was responsible: \_\_\_\_\_

Are you a member of a Private Health Insurer (e.g. BUPA, etc.)? **YES / NO**

If YES, advise Name of Insurer: \_\_\_\_\_ Policy / Membership No: \_\_\_\_\_

**This section must be completed in full**

Are you insured for this incident through any other Insurer? **YES / NO**

If Yes, advise name of Insurer: \_\_\_\_\_ Policy / Membership No: \_\_\_\_\_

**Please note Insurers have the right to recover any outlay if dual insurance is in force.**

Did you use the E1 11 form (EHIC) when abroad? **YES / NO**

## Medical - Claim Form (continued)

Did you have to return early as a result of your illness / injury?

**YES / NO**

If YES, please advise date & reason why: \_\_\_\_\_

**If you did not contact the Medical Assistance Company, please attach confirmation from the treating doctor that it was medically necessary for you to curtail your trip. Please state your expenses in the expenditure table below.**

Did you have to remain longer abroad and miss your planned departure as a result of your injury / illness? **YES / NO**

If YES, please advise why and state your expenses on the expenditure table below: \_\_\_\_\_

### Expenditure Details

**Please note: Food, telephone/fax charges and other miscellaneous costs are not covered.**

	Date Expense Incurred	Description of Expense (e.g. Prescription)	Name of Hospital / Clinic / Treating Doctor	Amount Claimed (State Currency)	Receipts attached? YES/NO	Have you paid the expense/ bill? YES/NO
Item 1						
Item 2						
Item 3						
Item 4						
Item 5						
Item 6						
<small>Please ensure that all receipts are cross referenced with the item number. (You can write the number on the top right hand side of your receipt / invoice).</small>				<b>TOTAL AMOUNT CLAIMED</b>		

Please remember to include all ORIGINAL documentation requested on page 1 of this form and summarised below.  
(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 and you were hospitalised or the costs exceed €500.00. Ensure all receipts are cross-referenced with the item number.**

**For Internal use only. Anti Fraud Checklist A>Rating B>Rating C>Rating Insured to be interviewed? YES NO**

**Medical Certificate – Medical Expenses**

To be completed if the 24 Hour Medical Assistance Company was not contacted, where the Insured was an in-patient in a Hospital outside the European Union.

**This section must be completed fully by the usual G.P. of the person whose death, injury or illness gave rise to the claim.  
This form is not valid unless it bears the relevant surgery or hospital stamp.**

Any expenses for the completion of this form are at the Insured's expense.  
Please complete all sections fully, using **BLOCK CAPITALS**.

**Claimant: Please complete questions 1, 2 & 3 prior to giving to the medical practitioner.**

1. Patient's Name: \_\_\_\_\_ 2. Booking Date: \_\_\_\_\_ 3. Date of issue of Insurance: \_\_\_\_\_

4. Age: \_\_\_\_\_ 5. Are you the patient's usual Doctor? **YES / NO** How long for?  
\_\_\_\_\_

**6. Details of the medical condition giving rise to the claim:**

Diagnosis / Condition: \_\_\_\_\_ Date of Diagnosis: \_\_\_\_\_  
Date of first attendance for this condition: \_\_\_\_\_ Was it medically necessary to curtail the trip: \_\_\_\_\_  
Did the patient contact you immediately upon return from abroad? **YES / NO** \_\_\_\_\_  
If YES, please advise date of consultation: \_\_\_\_\_

7. Was your patient referred to a consultant / specialist or hospital within :-  
a. 24 months of the purchase of insurance or the booking of the trip? **YES / NO**  
b. 18 months of the purchase of insurance or the booking of the trip? **YES / NO**  
c. 12 months of the purchase of insurance or the booking of the trip? **YES / NO**  
If YES, please provide full details including dates, condition, prescribed medicines and any follow up action:  
\_\_\_\_\_  
\_\_\_\_\_

8. Was your patient been placed on a waiting list, either for treatment or investigation within 12 months of the purchase of insurance or the booking of the trip? (See question 2). **YES / NO**  
  
If YES, please provide full details including dates of referral & procedure and condition.  
\_\_\_\_\_  
\_\_\_\_\_

9. Has your patient suffered from or received any form of medical advice, treatment, or medication within the past 18 months for:  
**Heart or circulatory related condition (e.g. hypertension, angina, stroke)?** **YES / NO**  
**A lung or breathing related condition?** **YES / NO**  
**Any form of cancer?** **YES / NO**  
**The particular condition, or associated condition, giving rise to this claim?** **YES / NO**  
  
If YES, please provide full details including dates, condition, prescribed medicines and any follow up action.:  
\_\_\_\_\_  
\_\_\_\_\_

10. Has your client received a terminal prognosis from a medical practitioner? **YES / NO**  
  
If YES, state date of prognosis: \_\_\_\_\_ Date when condition or related condition first arose: \_\_\_\_\_

11. If your patient is now deceased, was there any pre-existing condition that was a contributory factor to the cause of death. **YES / NO** IF YES, please elaborate: \_\_\_\_\_

12. At the date the insurance was issued, would your patient have been aware of any condition or circumstance that may possibly give rise to this claim? **YES / NO**  
IF YES, please give details and describe the condition: \_\_\_\_\_  
\_\_\_\_\_

**DECLARATION:**

I have examined the above and/or referred to the relevant medical records and declare the details are accurate and correct and that no material facts have been omitted. **OFFICIAL OFFICE STAMP**

**Signed:** \_\_\_\_\_ **Print Name:** \_\_\_\_\_

**Date:** \_\_\_\_\_