GROUP BUSINESS TRAVEL

Medical Expenses / Curtailment Claim Form

Once completed, please return your claim form to:

ONE Claims Ltd
1-4 Limes Court
Conduit Lane
Hoddesdon
Herts
EN11 8EP

Thank you for notifying us of your claim.

Please complete this claim form and return it to ONE Claims Ltd as soon as possible.

Please write in BLOCK CAPITALS.

Please provide full supporting documentation to avoid delays in processing your claim.

Company Details (The Assured)

Company name:

Company address:

Postcode:

Email:

Telephone:

Fax:

Company Contact Name:

Claimant Details (The Insured Person):

Title	Full Name(s)	Date of Birth	Position Held

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Claimant Details (The Insured Person):

Claimant address: ____

____

Postcode: ____________________ Email: ____________________

Telephone: ____________________ Fax: ____________________

Country of residence: ____

Certificate number: ____________________ Insurance Broker: ____________________

Travel Destination:

Country: ____________________

Resort: ____________________

Hotel: ____________________

Departure Date: ____/____/____ Return Date: ____/____/____

Purpose of trip: - (Delete as applicable) Business / Pleasure

If Business: - (Delete as applicable) Clerical / Manual

If Manual please provide details of nature of work: ____________________

____

If your Claim is agreed, how would you like to be paid?

Please tick box to choose preferred method of payment:

Cheque: ☐ Confirm Payee name: ____________________

Or direct to your bank account ☐ **(UK bank accounts only)**

Bank Name: ____________________ Branch: ____________________

Bank Sort Code: __ __ __ __ __ __ Account No: __ __ __ __ __ __ __ __

Account Holder: ____

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DOCUMENTS REQUIRED TO SUPPORT CLAIMS

IMPORTANT: ORIGINAL DOCUMENTS ARE REQUIRED.
WE CANNOT ACCEPT PHOTOCOPIES OR FAXED DOCUMENTS

Please Provide

1. All original receipts for expenses incurred **plus Original Booking invoice**.
2. Additional travel tickets.
3. Form E111 if not presented whilst abroad (European travel only).
4. In respect of claims following hospitalisation abroad, the attached Medical Certificate completed by your usual UK Doctor.
5. If hospitalised, written confirmation from the hospital concerned of date/time admitted and discharged.
6. Letter from the treating Doctor abroad confirming the medical necessity to return home to the U.K earlier than planned.
7. For claims where curtailment is as a result of illness/death which occurred in the U.K, completion of the attached medical certificate.
8. For Medical Expenses incurred in Europe only, please complete the attached disclaimer in full.

Medical Expenses & Curtailment

Date, time and place of illness/injury: ____ /____ / ____ ____ : ____ AM/PM ____________________

____

Illness suffered or injuries sustained: ____

____

Details of any previous history: ____

If injury, state circumstances: ____

____

Did you take with you Form E111: YES/NO Was it presented? YES/NO

Did you contact the emergency service as on the policy: YES/NO

Do you hold any private medical insurance e.g. BUPA, PPP etc? YES/NO

If YES, Policy Number/Scheme Name: ____

Period of extended accommodation (if applicable) from ____ /____ / ____ to ____ /____ / ____

What were your original return travel arrangements? ____

____

____

If hospitalised: Date/time admitted ____ /____ / ____ ____ : ____ AM/PM

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Were any additional expenses incurred in returning home? YES/NO (If yes, enter reasons and costs.)

____

____

In case of early return through illness, bereavement or injury please complete the following: ______________________________

Date on which you returned: ___ /___ / ___ Were you accompanied? YES/NO

If YES, by whom: ______________________________

Reason for the curtailment: ______________________________

____

Were any additional expenses incurred? YES/NO

PLEASE ENCLOSE WRITTEN CONFIRMATION FROM THE DOCTOR ABROAD THAT IT WAS MEDICALLY NECESSARY FOR YOU TO CURTAIL YOUR TRIP.

Please list expenses being claimed and treatment received	Currency paid and amount claimed	Receipt attached	State to whom payment should be made.

DECLARATION - This must be signed.

I/We declare that the above statements are true and correct to the best of my/our knowledge and belief. I/we have not withheld any information within my/our knowledge connected with this claim. I/we agree to provide the insurer with any further information as may be reasonably required. I/we understand that the insurer does not admit liability by issue of this form. **WARNING - the making of a fraudulent or knowingly exaggerated claim is a criminal offence. We investigate all cases and any person suspected of fraud is reported to the police with whom we always co-operate.**

DATA PROTECTION ACT

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and may be shared with other organisations for this purpose. I/We understand that you may ask for information from other organisations to check the answers I/we have provided.

Signature(s) ______________________________ Date ____ / ____ / ____

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MEDICAL CERTIFICATE

(TO BE COMPLETED BY THE GENERAL PRACTITIONER OF THE PERSON CAUSING THE CURTAILMENT - ANY FEE DUE IS THE RESPONSIBILITY OF THE CLAIMANT)

PLEASE NOTE:- To avoid delay and unnecessary correspondence please ask the Doctor to complete this Certificate in BLOCK CAPITALS and to answer each question as fully as possible.

1)	Full name of the person to whom these medical details apply	
2)	Date of birth and Age	DoB: ____ / ____ / ____ Age: ____
3)	Are you his/her usual general practitioner? If not, in what capacity are you involved?	
4)	Please state the exact nature of illness/accident which made cancellation necessary.	
5)	Is there any previous medical history of the above condition or other relevant condition? If YES, please give dates and details	
6)	When did the patient first consult you with regard to this condition?	Date: ____ / ____ / ____
7)	When was the condition diagnosed?	Date: ____ / ____ / ____
8)	When was cancellation deemed necessary?	Date: ____ / ____ / ____
9)	Were you aware of the travel plans when first consulted?	
10)	If NO please confirm the first date on which cancellation could have been anticipated.	
11)	PREGNANCY ONLY (a) Date of LMP (b) Date pregnancy confirmed (c) Estimate date of confinement Exact medical condition within pregnancy	a) Date: ____ / ____ / ____ b) Date: ____ / ____ / ____ c) Date: ____ / ____ / ____
12)	At the time the trip was booked, please state whether:- (a) The condition was under control. (b) This was an exacerbation of an existing condition and if so the date of the exacerbation. (c) The patient was either on a waiting list for in-patient treatment or was actually an in-patient. (d) The patient had received a terminal prognosis. (e) If the patient was one of those travelling, the condition was a contra indication to do so. (f) Was travelling contrary to medical advice?	a) YES/NO ____ b) YES/NO ____ Date: ________ c) YES/NO ____ Date: ________ d) YES/NO ____ Date: ________ e) YES/NO ____ f) YES/NO ____

I certify that the cancellation was due solely to the medical reasons stated.

Name & Signature: ____________________

Qualifications: ____________________ Tel No.: ____________________

PRACTICE STAMP

Disclaimer:

I hereby consent to ONE Claims Ltd seeking reimbursement of Medical Expenses paid by them arising out of medical treatment;

Received in: ______________________________ from: ____ / ____ / ________
(Destination) (Date of Accident/Illness)

Signed: ______________________________ Dated: ____ / ____ / ________

Print Name: ______________________________

Full UK Address: ______________________________
____
____

Postcode: ______________________________

Date of Birth: ____ / ____ / ________

Nationality: ______________________________

N.I. Number: ______________________________

Full Name of Child: (If Applicable) ______________________________

Date of Birth of Child:(If Applicable) ______________________________

Nationality of Child: (If Applicable) ______________________________

Date of Departure Abroad: ____ / ____ / ________