



**TRAVEL (MEDICAL EXPENSES) CLAIM FORM**

Claimant's Name: \_\_\_\_\_ Policy Number: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_ Telephone number: \_\_\_\_\_

Name, address and telephone number of person handling claim, if different from above:

\_\_\_\_\_

Date of accident / onset of illness : \_\_\_\_\_

Circumstances of accident (if applicable) : \_\_\_\_\_

\_\_\_\_\_

Nature of injuries / illness : \_\_\_\_\_

\_\_\_\_\_

Is this injury or illness connected to any injury or illness you have suffered from in the past?

(If Yes please provide details)

Yes  No

\_\_\_\_\_

\_\_\_\_\_

**Details of expenditure**

Nature of Expenditure	To Whom Paid	Amount	Paid / Unpaid

*Please attach: Tour Operator's original letter of confirmation of booking, medical bills covering the full amount of the claim and receipts and/or bills for any additional expenditure incurred.*

Total amount of claim : £ \_\_\_\_\_

I declare that these particulars are true to the best of my knowledge.

Signature : \_\_\_\_\_

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