



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 : _____

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 : _____