



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

GROUP BUSINESS TRAVEL

Medical Expenses / Curtailment Claim Form



CLAIMS

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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CLAIMS

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



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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: ___ / ___ / _____