PA **PERSONAL ACCIDENT**

Postcard Claims
1 Tower View,
Kings Hill,
West Malling,
Kent
ME19 4UY
Email:
claims@postcardtravelinsurance.co.uk
Web:
www.postcardtravelinsurance.co.uk

Dear Customer,

In order that we can process your claim quickly, please complete all relevant sections of the claim form, giving as much detail as you can and **return it to us at the above address,** together with the following **ORIGINAL** documentation. Please note that in the interest of protecting ourselves from fraud we are unable to accept photocopied receipts or invoices.

We recommend that you keep your own copy of all documents forwarded to us.

To help you enclose the correct paperwork to support your claim we have put together a checklist. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

CHECKLIST OF DOCUMENTS REQUIRED

ALL CLAIMS

- [ ] DOCUMENTATION SHOWING YOUR TRAVEL DATES AND FULL COST OF THE TRIP (booking invoice)
- [ ] PROOF OF INSURANCE (i.e. certificate/schedule or confirmation email). As claims handlers we do not hold this information.
- [ ] OUR MEDICAL CERTIFICATE COMPLETED BY THE GENERAL PRACTITIONER OR CONSULTANT OF THE PERSON CLAIMING UNDER THIS SECTION
- [ ] COPIES OF ANY MEDICAL REPORTS AVAILABLE
- [ ] AN CERTIFIED COPY OF THE ORIGINAL DEATH CERTIFICATE
- [ ] CORONERS REPORT (if applicable)
- [ ] LETTERS OF ADMINISTRATION OR GRANT OF PROBATE (to enable us to identify the correct beneficiary)
- [ ] ACCIDENT REPORT OR POLICE INCIDENT REPORT
- [ ] INDEPENDENT WITNESS REPORTS

You should note that all the information provided to us on this form will be stored electronically in accordance with The Data Protection Act and shared with the Insurance Industry Fraud Prevention Unit. If you make a fraudulent or intentionally exaggerated claim this will invalidate your claim and we will pursue a recovery through the civil courts in all cases.

We do understand that it may take time to collect all the documentation required but please try to submit your claim as soon as possible after the event. In the event of documentary delays, please send in what you have available to register your claim.

Yours faithfully

Travel Claims Facilities

CLAIM FOR PERSONAL ACCIDENT – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

TO BE COMPLETED BY THE CLAIMANT

Title:

First Name: **Surname:**

Address:

Post Code:

Telephone: **Date of Birth:** DD / MM / YY

Email:

DETAILS OF THE INSURANCE POLICY

Where / who did buy your insurance from:

Policy name: **Date Policy Issued:** DD / MM / YY

Policy number: **Master Policy Number:**

Found on Schedule, Certificate, or Booking Invoice

Found on policy wording (ABCDE 400…)

Destination:

i.e. Europe / Worldwide

Medical Screening reference number:

DETAILS OF TRIP

Travel Agent / Tour Operator:

Date Trip Booked: DD / MM / YY **Date final balance paid:** DD / MM / YY

Method of payment (cash, cheque, debit card, credit card):

Trip Dates **From:** DD / MM / YY **To:** DD / MM / YY

DETAILS OF CLAIM

Incident Date: DD / MM / YY **Time:** HH / MM **AM:** **or PM:**

Where did the accident occur:

What injuries were sustained:
Please include details such as right/left leg or arm etc.

Where were you treated:
Name and address of hospital or clinic

What was the name of the doctor who treated you:

EMERGENCY ASSISTANCE SERVICE

Did you contact our emergency assistance Service for advice: Yes: **No:** **If yes, please advise:-**

Date and time of your first call: DD / MM / YY - HH / MM **Reference number given:**

What is the name of the person handling your case:

Have you submitted a claim for medical expenses: Yes: **No:** **Claim number:**

CLAIM FOR PERSONAL ACCIDENT – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

PLEASE GIVE A FULL DESCRIPTION OF THE CIRCUMSTANCES GIVING RISE TO THE INJURY:

Please advise details of your usual GP:

Name:

Address:

Post code:

Please advise details of your treating specialist:

Name:

Address:

Post code:

THIRD PARTY INFORMATION

Was anyone else involved in this incident: Yes: No: If yes, please complete the details below:

Name:

Address:

Post code:

Name:

Address:

Post code:

Please describe their involvement in your injury:

WITNESSES

Were there any witnesses to the accident? If so, please provide details:

Name:

Address:

Post code:

Name:

Address:

Post code:

CLAIM DECLARATION:

- ✓ I/We declare that all the details provided above are true and accurate to best of my knowledge.
- ✓ I/We give consent for Travel Claims Facilities to seek recovery of monies paid where other insurers cover the same risk, or from third parties who may be held liable.
- ✓ I/We understand that details of this claim may be passed to the insurance industries central claim register
- ✓ I/We understand that if a claim is found to be fraudulent of exaggerated that this will invalidate the whole claim and Travel Claims Facilities may seek to recover any costs through the civil courts.
- ✓ I/we confirm that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf , and I confirm that I understand that neither Travel Claims Facilities or the underwriters of the policy will accept responsibility if any payments are not distributed proportionately to the persons concerned

Once you have read and agreed to the above declarations, please sign and date below.

Signed:

Dated: DD / MM / YY

Please print name:

MEDICAL CERTIFICATE

This medical certificate is to be completed by the General Practitioner of the person whose death, illness or injury caused this claim. NOTE: Any charges for completion of this form are the responsibility of the claimant.

Doctors Name:

Doctors Qualification:

Telephone Number:

Doctors Signature:

Date: DD / MM / YY

Surgery Stamp

PLEASE ANSWER ALL QUESTIONS IN FULL (n/a or dashes are not acceptable).

Patients name: **Date of Birth:** DD / MM / YY

Patients address:

Post code:

1. **Please state the precise nature of medical condition / illness / injury / cause of death:**

2. **Has the patient suffered from PERMANENT AND TOTAL loss of or loss of use of any of the following:**

   a) **HAND: Left: Right: If yes, date confirme** DD / MM / YY

   b) **FOOT: Left: Right: If yes, date confirmed:** DD / MM / YY

   c) **PERMANENT AND TOTAL loss of sight in one or both eyes: Yes: No: If yes, date confirmed:** DD / MM / YY

   d) **Has the patient suffered from PERMANENT AND TOTAL DISABLEMENT preventing them from engaging in any paid employment or paid occupations:**

   Yes: No: If so, date confirmed: DD / MM / YY

3. **What date did the accident occur:** DD / MM / YY **Date you were first consulted:** DD / MM / YY

4. **If accidental injury, please state how this was caused:**

5. **Are the injuries solely due to the accident: Yes: No:**

6. **Is the patient now, or was the patient at the time of the accident, suffering from any illness or disease, irrespective of their injuries? If so, please state the nature of those conditions and to what extent this will/has effected their recovery:**

7. **Could the injuries be attributable to any other cause: Yes: No:**

8. **Please advise the date of any previous diagnosis:** DD / MM / YY

9. **Was the patient referred to a consultant? Yes: No: Date patient seen by consultant:** DD / MM / YY

   Please advise their name, title and hospital address:

10. **Date/s and results of any relevant diagnostic tests:**

11. **Please advise if this condition has caused the patient to be hospitalised and the dates involved:**

12. **Please list all regularly prescribed medication including inhalers along with date first prescribed:**

In order for us to obtain any further medical reports, would you please be kind enough to complete and sign the details below and return this form to us, which will allow us to contact your / the patient's General Practitioner for more detailed information which will assist in the assessment of your claim. We will pay any costs incurred in relation to additional information being requested by us.

ACCESS TO MEDICAL REPORTS ACT 1988

This policy is insured by Union Reiseversicherung UK (URV), if they or any of their agents require information from your doctor in respect of your insurance you have certain rights under the Access to Medical Reports Act 1988: -

- Your consent* is required before URV or anyone acting as their agent can apply for a report and you may see the report before it is supplied to URV or their agents, or at any time during the six months after that.
- If you disagree with the contents of the report or consider it to be misleading you may ask your doctor to amend it. If the doctor disagrees you may add your own written comments. The doctor may withhold all or part of the report from you if he/she thinks that this would be in your best interests, or that of others. . Alternatively you can refuse consent*.
- At no time will the report be sent to URV or anyone acting as their agent without your consent.

*You can refuse to give your consent however this may mean we are unable to deal with your claim

Charges made by the doctor for providing such a report to URV are for your own account, as they are not covered by this policy.

DETAILS OF THE PATIENTS/YOUR USUAL GENERAL PRACTIONER

Patient Name:

Name of General Practitioner:

Surgery Address:

Post Code:

Telephone Number:

Name of Hospital admitted to (if applicable):

Consultant Name:

DECLARATION

I consent to URV or anyone acting as their agent, seeking medical information from any doctor who has any at any time attended me concerning anything which affects my/the patient's physical and/or medical health. I authorise the giving of such information during and after my lifetime.

I have been informed of and understand my rights under **Access to Medical Reports Act 1988** (see above).

I do / do not wish to see any report before it is sent: I do: **I do not:**

Patients name: **Date of Birth:** DD / MM / YY

Patients address:

Post code:

Signature of patient or **Signature of next of kin** **Date:** DD / MM / YY

Please print name:

If next of kin, please advise your relationship to the patient:

Postcard Claims
1 Tower View,
Kings Hill,
West Malling,
Kent
ME19 4UY
Email:claims@postcardtravelinsurance.co.uk
Web:
www.postcardtravelinsurance.co.uk

SETTLEMENT BY BACS

For your convenience and to offer an efficient smoother service, we would like to pay any claim settlement due directly into your bank account. Please provide your details on this form, remembering to sign and date below.

If you do not wish to provide your bank details, any settlement due on your claim will be issued by cheque and may take a little longer to process.

YOUR DETAILS

Name of Claimant

BANK ACCOUNT DETAILS

Name of Payee

This should be the same as held on the bank account

Bank Name

Bank Address

Bank Address

Bank Address

Country **Post Code**

Bank Account number

Sort Code - -

Signed **Dated**

If your bank account is held abroad, please also enter the following details:

IBAN / BIC number

Swift code

We do not accept liability for any errors due to the incorrect bank details being provided by you.

Office Use Only	URV	£	Auth:	Dated: