MAPFRE Middlesea p.l.c.
Middle Sea House, Floriana FRN 1442 Malta
T: (+356) 2124 6262
mapfre@middlesea.com
Registration Number: C5553

Travel Insurance Claim Form

IMPORTANT NOTE

Insurers, their Agents and Insurance Associations share information with each other to prevent fraudulent claims and for underwriting purposes. In the event of a claim, some or all the information you supply on this form and the proposal form together with other information relating to the claim may be provided to other Insurers, their Agents and Insurance Associations.

ALL RELEVANT QUESTIONS MUST BE FULLY ANSWERED

1. INSURED/CLAIMANT'S DETAILS (this section must be completed by all claimants)

Title:	
(Sur)name of policyholder:	
Policy no.:	Travel scheme (if applicable e.g. BOV card holder, La Vallette, Flypass etc.):
Claimant's name:	
Address:	
I.D. card no.:	
Tel/Mob. no.:	E-mail:
Date of departure:	Date of return:
Destination/Countries:	
Purpose of journey ☐ Holiday ☐ Business ☐ Other (please specify):	
Are you insured by any other policy in respect of this claim? YES ☐ | NO ☐ If "YES", please give name and address of Insurers and policy number:	
Have you ever claimed under a travel policy in the past? YES ☐ | NO ☐ If "YES", please give details of the claim:	

2. CANCELLATION and ABANDONMENT

Date of cancellation/abandonment:

Please give reasons for cancellation/abandonment.
(If the reason is related to DEATH, INJURY or ILLNESS please complete **SECTION 6 - MEDICAL INFORMATION**)

State amounts claimed and attach receipts:

Was the travel agent or ticket issuing office notified immediately of the cancellation? YES ☐ | NO ☐

Please specify the amounts recovered, if any (Attach any relevant booking conditions):

Number of persons claiming:

3. PERSONAL ACCIDENT (Please also complete Section 6 - MEDICAL INFORMATION)

Date of accident:	Time of accident:

Place of accident:

Give full description of the circumstances and details of the injury:

Has claimant been totally disabled as a result of this accident? YES ☐ | NO ☐

When did total disablement start?

Is claimant still totally disabled? YES ☐ | NO ☐

When does claimant expect to resume part, if not all, normal business?

4. MEDICAL EMERGENCY AND ASSOCIATED EXPENSES (Please also complete Section 6 - MEDICAL INFORMATION)

Give details of injury or illness necessitating medical attention:

Date of occurrence:

Detail the expenses incurred (Attach receipts):

Please specify details of any Private Health Insurance which also covers you for the above expenses:

Date

Patient's signature (If the patient is under 18 years of age, then the legal guardian must sign)

5. HOSPITAL BENEFIT (Please also complete Section 6 - MEDICAL INFORMATION)

Reason for admittance to hospital:

Date and time admitted to hospital:

Date and time discharged from hospital:

Attach hospital report.

6. MEDICAL INFORMATION (Please complete for Sections 2-5)

Name of doctor giving initial treatment in respect of this illness or injury:

Address:

Has the person concerned ever suffered from this type of illness or injury before? YES ☐ | NO ☐

If "YES" give details:

Name of usual doctor:

Address of usual doctor:

If "NOT" claimant, give name, address and relationship:

Has he/she been consulted in respect of this illness or injury? YES ☐ | NO ☐

7. DELAYED AND MISSED DEPARTURE

Reasons for delayed or missed departure:

Date and time of original departure:

Date and time of rescheduled departure:

Reasonable expenses incurred as a result of missed or delayed departure. (Attach receipts):

8. PERSONAL BELONGINGS AND MONEY, LOSS OF PASSPORT, RENTAL VEHICLE POLICY EXCESS AND DELAYED LUGGAGE

Date and time of loss, damage or delay	
Time luggage delivered	Place:
State the precise circumstances in which loss, theft, damage or delay occurred:	
State amounts claimed and attach receipts:	
Was the travel agent or ticket issuing office notified immediately of the cancellation? YES ☐ | NO ☐ Please specify the amounts recovered, if any (Attach any relevant booking conditions):	
Number of persons claiming:	
Name and address of witness(es):	
Was the airline notified of your loss, damage or delay? YES ☐ | NO ☐	
Were the police notified of loss and/or theft? YES ☐ | NO ☐ If "YES", when and at which station:	

LOSS OF PASSPORT

List details and amounts claimed in respect of additional accommodation and travel expenses incurred if you lose your passport whilst you are abroad (Attach invoices/receipts).

PERSONAL BELONGINGS

Description of lost, stolen or damaged property (including make and model) or items bought as emergency expenses	Date of purchase	Original purchase price in EURO	Value at the time of loss after allowing for wear and tear in EURO	Net amount claimed in EURO
TOTAL AMOUNT CLAIMED:				

PERSONAL MONEY

Currency	Amount
TOTAL AMOUNT CLAIMED IN EURO	

Please attach original receipts, invoices and/or proof of purchase.

PAYMENT DETAILS - ***Let us know your bank account details for processing of payment***

Use the bank details below for this and future claims YES ☐ | NO ☐
IBAN:
Account Holder Name:

DATA PROTECTION

Mapfre Middlesea p.l.c. is legally bound to follow the provisions of the Data Protection Act, 2001 Mapfre Middlesea p.l.c. is registered with the Office of the Commissioner for Data Protection to process data in accordance with this Act. The Data Protection Policy of Mapfre Middlesea p.l.c. is compliant with this Act, a copy of which is available on request.

DECLARATION

I/We hereby declare that, after checking all details, the above information and statements are, to the best of my/our knowledge and belief, correct and complete. I understand that in the event of an incomplete and/or non-disclosure of material information, MAPFRE Middlesea p.l.c reserves the right to repudiate the claim. Furthermore, I declare that I have not withheld any information relevant to the claim and assume full responsibility for the statements being made.

If the answers to all or any of the above questions have been written by others at my/our dictation or instruction I/We confirm that I/We have read those answers and that they are correct and that such person completing this form on my/our dictation or instruction for this purpose will be regarded as my/our agent.

I give explicit and unequivocal consent to MAPFRE Middlesea p.l.c. to seek any information from any doctor, surgeon, hospital, clinic, laboratory or persons that have records or knowledge of my health in order for the validity of the claims to be established. I hereby authorise any doctor, surgeon, hospital, clinic, laboratory or persons that have records to provide full medical information concerning myself and my dependants.

Date:
Signature of policyholder:
Date:
Signature of claimant:

DOC.NO.TRVCF-V2.0-010823
COM. NO. MMS080523/1