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Travel Insurance Claim Form

IMPORTANT NOTES
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/PATIENT'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:
Business or occupation:	Date of birth:
Status of claimant: ☐ Single ☐ Married ☐ Separated ☐ Divorced	
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: w	
Have you ever before claimed under a travel policy? 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:

DECLARATION I authorise MAPFRE Middlesea p.l.c. to share information with others (including insurers and Insurance Associations) in order to prevent fraudulent claims. I declare that all the answers given and the statements made are true and correct. Furthermore I declare that I have not withheld any information relevant to the claim. 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. I give consent to MAPFRE Middlesea p.l.c. to process my personal data supplied by myself or any person, body or entity in order to process, handle and settle the claim.

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:	
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.

I/We hereby declare that the above information and statements are, to the best of my/our knowledge and belief, correct and complete.

Date:
Signature of policyholder:

Date:
Signature of claimant:

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.