PO Box 420
Hadlow
Kent
TN9 9DE

tel: 08453 707 187
fax: 0870 620 5001
web: www.tif-plc.co.uk

PA Personal Accident

We are sorry to learn that you need to make a claim on your travel insurance policy.

In order that we can process your claim quickly please complete all the relevant sections of the claim form in full and return it to us at the above address together with the following **ORIGINAL** documentation. In the interest of protecting ourselves from fraud we are unable to accept photocopied documents.

CHECKLIST OF DOCUMENTS REQUIRED tick the box to indicate to us which ones we should expect to find enclosed

*Essential Items

- ☐ * BOOKING INVOICE
- ☐ * PROOF OF PURCHASE OF INSURANCE (i.e. certificate or premium receipt. As claims handlers we do not hold this information)
- ☐ * MEDICAL CERTIFICATE COMPLETED BY YOUR GENERAL PRACTITIONER/CONSULTANT
- ☐ ORIGINAL DEATH CERTIFICATE
- ☐ CORONERS REPORT
- ☐ LETTERS OF ADMINISTRATION/GRANT OF PROBATE
- ☐ ACCIDENT REPORT/POLICE INCIDENT REPORT
- ☐ INDEPENDENT WITNESS REPORTS
- ☐ PHOTOCOPY OF ANY OTHER RELEVANT INSURANCES

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 . Your failure to supply all documentation will delay settlement of your claim.

Yours sincerely,

Travel Claims Facilities

Please note our return address is: PO Box 420, Hadlow, Kent, TN9 9DE

Travel Claims Facilities is a division of Travel Insurance Facilities PLC. Registered Office: 10 Victoria Road South, Southsea, Hampshire P05 2DA Registration No.3220410
Travel Insurance Facilities plc are authorised and regulated by the Financial Services Authority Travel Insurance Facilities plc are members of the Financial Compensation Scheme

insurance | screening | administration | claims | assistance

CLAIM FOR PERSONAL ACCIDENT – [ ]

Please complete all sections of this form and then check the list of additional documents you need to send in order that we can assess your claim immediately.

PO Box 420
Hadlow
Kent
TN9 9DE

tel: 08453 707 187
fax: 0870 620 5001
web: www.tif-plc.co.uk

DETAILS OF THE INSURED PERSON

Title | Surname

First Name (s)

Address

Postcode

D.O.B. DD / MM / YYYY | National Insurance No.

Telephone Number | E-mail

Occupation

DETAILS OF THE INSURANCE POLICY

Place Purchased | Scheme of Insurance

Telephone No. | Policy No. (found on correspondence)

Cert / Receipt No. (found on booking invoice) | Date Issued DD / MM / YYYY

Dates of Trip DD / MM / YYYY to: DD / MM / YYYY | Trip Destination

Medical Screening Case No. (if applicable) | Master Policy No. (found on policy wording)

DETAILS OF TRIP

Travel Agent/Tour Operator | Tel No.

Date of Booking DD / MM / YYYY | Date Final Balance Paid DD / MM / YYYY

Method of Payment (Cash/Cheque/Debit Card/Credit Card)

DETAILS OF CLAIM

Date: DD / MM / YYYY | Time: | Place:

Where were you treated?

What was the name of the doctor who treated you?

Did you contact our appointed emergency assistance service (EMS) for advice? Yes [ ] No [ ]

Date of your first call DD / MM / YYYY | Time | Reference No. Given

Name of the person handling your case:

Have you submitted a claim for medical expenses: Yes [ ] No [ ] | Claim No. Given

CLAIM FOR PERSONAL ACCIDENT – [ ]

Please complete all sections of this form and then check the list of additional documents you need to send in order that we can assess your claim immediately.

PO Box 420
Hadlow
Kent
TN9 9DE

tel: 08453 707 187
fax: 0870 620 5001
web: www.tif-plc.co.uk

DETAILS OF CLAIM Cont.

Please give a brief description of the circumstances giving rise to the injury (s)

Please continue on a separate sheet should you need more space

THIRD PARTIES INVOLVED

Do you believe a third party was responsible for this incident:

Yes No

Details of third party:

Name

Address

Postcode

Telephone

If yes, please explain why:

NAMES AND ADDRESSES OF WITNESSES

Name

Address

Postcode

Telephone

Name

Address

Postcode

Telephone

DECLARATION

- ✓ I/We declare that all the details provided above are true and accurate to the best of my knowledge.
- ✓ I/We give consent for Travel Claims Facilities to seek recovery of monies paid where reciprocal agreements are in force, or from other insurers covering 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 or exaggerated that this will invalidate the whole claim and TCF may seek to recover any costs throught the civil courts.

Signed

Dated DD / MM / YYYY

Name

CLAIM FOR PERSONAL ACCIDENT – [ ]

MEDICAL CERTIFICATE TO BE COMPLETED BY THE GENERAL PRACTITIONER

NOTE: any charges for completion of this form are the responsibility of the claimant

PO Box 420
Hadlow
Kent
TN9 9DE

tel: 08453 707 187
fax: 0870 620 5001
web: www.tif-plc.co.uk

Doctors Name

Doctors Qualifications

Telephone Number

Date DD / MM / YYYY

SURGERY STAMP

Doctors Signature

Please answer all questions in full. N/A or dash's are not acceptable.

Name of Patient

Date of Birth DD / MM / YYYY

Address

Postcode

1. Please detail the injuries and outline the cause as far as you know
2. What date did you first see the patient in respect of these injuries DD / MM / YYYY
3. Nature and extent of injuries:

   Areas of body affected:
   (if hand, arm, foot, or leg, state whether right or left)
4. Are the injuries sustained due to the accident alone? Yes No
5. Are the injuries attributable to any other cause? 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, state the nature and to what extent this affects the recovery:
7. Are you aware of any previous medical history, which might have contributed directly or indirectly to the occurrence of the accident, or which may be likely to retard in any way the recovery from it?
8. Has the patient suffered:

   a. Total permanent loss of sight in one or both eyes or total loss by physical severance or total and permanent loss of use of one or both hands or feet?

   Yes No If yes, date confirmed: DD / MM / YYYY

   b. Permanent and total disablement preventing from engaging in paid employment or paid occupations of any and every kind?

   Yes No If yes, date confirmed: DD / MM / YYYY
9. If the patient has been under the care of another consultant of hospital please provide details:

Travel Claims Facilities is a division of Travel Insurance Facilities PLC. Registered Office: 10 Victoria Road South, Southsea, Hampshire P05 2DA Registration No.3220410
Travel Insurance Facilities plc are authorised and regulated by the Financial Services Authority Travel Insurance Facilities plc are members of the Financial Compensation Scheme

insurance | screening | administration | claims | assistance

Access to Medical Reports Act 1988

PO Box 420
Hadlow
Kent
TN9 9DE

tel: 08453 707 187
fax: 0870 620 5001
web: www.tif-plc.co.uk

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

In order for us to obtain the required report would you please be kind enough to complete and sign the details below and return this form to us at the address given above 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.

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 your/the patients usual General Practitioner:-

Name of patient	
Name of General Practitioner	
Surgery address Postcode	
Telephone number	
Hospital admitted to (if applicable)	
Name of consultant	

Declaration

I consent to URV or anyone acting as its 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 Address Postcode	
Date of Birth	DD / MM / YYYY
Signature of patient/next of kin	

Print Name ______ Date DD / MM / YYYY