Canopius Underwriting Limited
Medical & Other Expenses Insurance

Claims Form

Thank you for notifying us of your claim.

Please provide full supporting documents and answer all questions in full.

Please refer to the guidance notes for documentation we require.

Please return the completed form to your Insurance Broker or the office detailed below.

Canopius Underwriting Limited
Gallery 9, One Lime Street
London EC3M 7HA

Tel. 020 7337 3700
Fax. 020 7337 3999

CANOPIUS

Guidance Notes

Please note that if you are unable to supply any of the evidence we request, you should include a separate covering note explaining this. This will enable us to deal with your claim promptly.

In all cases, original documents must be provided. We are unable to accept photocopies (unless stated).

It is important that you provide evidence to support ownership and value of items. We appreciate that this may not always be possible. You should submit items marked* wherever you can. In some instance you might be able to provide photographs of items claimed for. These may help us in our assessment of your claim.

Please provide the following for all claims:

- The Tour Operator's, Travel Agent's or Carrier's Booking Invoice.
- Any tickets (used or unused) that relate to this travel.
- A copy of your Certificate of Insurance or Insurance Schedule.
- The medical certificate on the back of this claim form must be completed by the usual medical practitioner of the ill/injured/deceased person. If the claim form is returned and the medical certificate is not completed, we reserve the right to require its completion at a later stage.

For medical and other expenses (including the additional cost of return to the United Kingdom) claims the following should be provided:

- Invoices from service providers showing charges made against you, together with all receipts you received confirming payment.
- If you returned earlier or later than planned you should submit the medical certificate issued by the doctor who treated you abroad showing that your return was necessary on medical grounds.
- If you received treatment in an EEC country you should submit a completed EHIC card form which can be obtained from your local Post Office. You must also complete and sign the disclaimer section on the claim form.

For curtailment claims the following should be provided:

- The medical certificate issued by the doctor who treated you abroad showing the medical need to return home earlier than planned

Check List

The following is provided for your convenience to enable you to check that you have sent the appropriate information to us.

- Booking invoice ☐
- Medical Certificate completed ☐
- Insurance Certificate ☐
- Medical Certificate obtained abroad ☐
- EHIC ☐
- Date claim form posted_____
- Claim Form ☐
- Death certificate ☐
- All used / unused tickets ☐
- Expense receipts ☐

Policy Number _____ / _____ Date Issued _____

Insurance issued by _____

(agent's name and address) _____

Date Trip Booked _____ Date of Departure _____ Date of Return _____

Insured Person's Surname _____ Initials_____ Title (Mr/Mrs etc) _____ Date of Birth _____

Name of Policyholder (if different from Insured Person)_____

Address for correspondence _____

_____

Postcode _____ Occupation _____

Telephone Number (home) _____ Telephone Number (work) _____

Fax Number _____ Email address_____

Do you have any other insurance in force such as travel insurance on a credit card/bank account or company travel insurance with your employer under which this claim or part thereof may be recoverable?

YES / NO

If YES please provide Insurance Co. Name _____

Address_____

_____

Policy number_____

Name of the ill/injured person_____ Date of birth _____

Details of illness/injury suffered _____

_____

Date illness/injury commenced_____

Was the 24 hour emergency service contacted? YES / NO If YES please confirm by who _____

_____ and date of initial contact _____

If the injury was the result of an accident please give full details including dates and the names of any other parties involved with their insurance details if known. _____

_____

_____

_____

Date and time of admission to hospital _____ Date and time of discharge_____

Name and address of hospital _____

_____

_____

Did you return from your holiday earlier than planned? YES/NO If YES on what date _____

Are you claiming for any unused accommodation or travel? YES/NO If YES please give details _____

_____

_____

Expenses incurred

Date expense incurred	Name and address of service provider	Was an E111 presented? YES/NO	Amount of expense. Please indicate clearly the currency	Paid by you? YES/NO	For office use only

DISCLAIMER **The following should be completed and signed by those who incurred medical expenses in an EC Country**

I hereby consent to **Underwriters** seeking reimbursements of medical expenses paid by them out of medical treatment received in (country) _____ from an illness/injury which commenced on (date) _____

Signed _____ Date _____

PLEASE NOTE THAT ALL CLAIMANTS MUST SIGN THE DECLARATION BELOW

Do you have Private Health Insurance? YES/ NO

If YES please provide

Insurance Co. Name _____

Address _____

_____

_____ Policy No. _____

DECLARATION

I understand that the making of a fraudulent claim by providing untrue information is a criminal offence likely to lead to prosecution. I confirm that the information given on this form and information provided by myself on pages attached to this form is, to the best of my knowledge and belief, true in every respect and that the amounts claimed have not been refunded to me or claimed from any other source.

YOU MUST READ THE DECLARATION BEFORE SIGNING.

PLEASE READ AND SIGN THE ACCESS TO MEDICAL RECORDS CONSENT FORM OVERLEAF.

Signed _____ Date _____

Please use additional paper if space provided on this form is insufficient; please attach additional paper when submitting this form.

Number of additional pages attached :_____

MEDICAL REPORT CONSENT FORM

Full name of Claimant_____ Date of Birth _____

Full name of Patient if different from Claimant_____

Date of Birth _____

Address:_____

_____

_____

General Practitioner_____ Address_____

_____

Specialist_____ Address_____

_____

I hereby consent to a medical report or my records being supplied in confidence to the Insurers Medical Adviser by the above named doctor(s) or their nominated deputy. I understand that it may be necessary for the Insurers or their representatives to discuss some of these matters in the strictest confidence with their personnel in order to assess the claim being made under the relevant policy/policies.

I understand my rights under the Access to Medical Reports act 1988 and have read the summary of my principal rights under this act (please see overleaf).

Delete where inapplicable

- I DO NOT wish to have access to the medical report or notes before they are supplied.
- I DO wish to have access to the medical report or notes before they are supplied and understand that I have 21 days in which to make the necessary arrangements with my medical practitioner, who is entitled to charge a fee for this service.
- I agree to be seen and examined by the Insurers Medical Adviser. I also understand that any information or opinions drawn from his examination of me may also be divulged to the Insurers (or agreed third parties) and also understand that this may be used in making underwriting and claims decisions.

A copy of this consent shall be valid as the original.

Signed _____ Date _____

ACCESS TO MEDICAL REPORTS 1988

This is a summary of your principal rights under the Act, which is concerned with reports provided for employment or insurance purposes by a medical practitioner who is, or has been, responsible for your care.

Option A. You may withhold your consent for the report from a medical practitioner.

Option B. You may consent to the application but indicate your wish to see the report before it is supplied. (You must make the necessary arrangements with the medical practitioner to see the report It will not be sent to you automatically).

The medical practitioner will be informed that you wish to have access to the report and will allow 21 days for you to see and approve it before it is supplied to the applicant. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made, he/she will assume that you do not wish to see the report and that you consent to its being supplied.

When you see the report, if there is anything in it which you consider incorrect or misleading, you can request (but this request must be in writing) that the medical practitioner amend the report, but he/she is not obliged to do so. If the medical practitioner refuses to amend it, you may :

i) withdraw consent for the report to be issued.

ii) ask the medical practitioner to attach to the report a statement setting out your own views.

iii) agree to the report being unchanged.

NOTE: The medical practitioner is not obliged to show you any parts of the report which he/she believes might cause serious harm to your physical or mental health or that of others, or which would reveal information about a third party or the identity of a third party who has supplied the practitioner with information about your health, unless the third party also consents. In those circumstances the medical practitioner will so inform you and your access to the report will be appropriately limited.

Option C. You may consent to the application for the report, but indicate that you do not wish to see the report before it is supplied. Should you change your mind after the application is made, and notify the medical practitioner in writing, he/she should be allowed 21 days to elapse after such notification so that you may arrange to have access to the report (if the report has not already been supplied before you change your mind).

Option D. Whether or not you do decide to seek access to the report before it is supplied, you have the right to seek access to it from the medical practitioner at any time up to six months after it was supplied.

Please note that where a copy of the medical report is supplied to you, the practitioner may charge a reasonable fee to cover the cost of supplying it.

MEDICAL REPORT

Claimant details:

Name of Claimant _____

Name of Patient if different from Claimant _____Patient's Date of Birth_____

Relationship to Claimant_____

Doctor's Report

Dear Doctor,

The above named person has submitted a claim under their Travel Insurance Policy. In order for us to assess the claim we would be grateful if you would answer the questions below.

Name of person to whom this report refers (the patient) _____

Are you the patient's usual practitioner? YES / NO

How long have you acted in this capacity? _____ Years.

What is the precise nature of the condition, illness or injury that has caused a claim to be made under this policy?

_____

_____

When were you first consulted about this condition? _____

Has the patient suffered from the same or a similar condition in the past? YES / NO

If so please advise dates of all previous treatments _____

Has the patient been included on a waiting list for in-patient treatment for this condition? YES / NO

If so please advise the date they were put on the list _____

If the cancellation was due to pregnancy please advise: -

Date pregnancy was confirmed _____

Expected date of delivery _____

Did the patient consult you for permission to travel? YES / NO if YES please give date _____

If so did you consider the patient fit to travel at the time? YES / NO

What date did you advise the patient to cancel their holiday arrangement?____

DECLARATION

I have examined the patient and/or his medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signed _____ Practice stamp:

Name _____

Qualification _____