Medical & Curtailment Claim Form

Please complete all relevant sections of this Claim Form and return to:
P J Hayman Claims Department, Stansted House, Rowlands Castle, Hampshire PO9 6DX
Email: **claims@pjhayman.com**

Claim Number | | | | | | | | | | (for office use only)

If you require a large print version, please call 02392 419 020
Please use **BLOCK CAPITALS** when filling in your form. If there is insufficient space for your answers please, use the Additional Information sheet on page 6.

Check List of Required Documents

Please send the following to support your claim.

If you do not enclose all the documentation we have listed any settlement of your claim will be delayed.

Tick ✓against documentation enclosed.

- ☐ Insurance Schedule (if you have an Annual Insurance a copy would be sufficient).
- ☐ Medical Pre-screening Confirmation (if applicable).
- ☐ Holiday Booking invoice showing the date the holiday/trip was booked, who was booked to travel, travel dates, destination, amounts paid and purchase of your travel insurance (if applicable).
- ☐ All Medical Receipts and Invoices (French medical accounts should be signed by you in the 'signature de l'assuré' box before submitting them). We are unable to accept costs which are not supported by proof of payment.
- ☐ A Medical report from the treating doctor.
- ☐ The Pension Service Form (where enclosed).
- ☐ The Medical Certificate completed by the usual treating GP of the person causing the claim (where enclosed). Other documents, such as hospital letters or death certificates, may be considered, although if submitted instead of the GP completed medical certificate, it may be necessary to request additional information.

FOR SKI PACK CLAIMS ONLY (the following additional information is required)

- ☐ Written Confirmation from the treating doctor that you were unable to use the remain proportion of your ski pack.
- ☐ Original Receipts/Invoices for the Ski Pack items showing how many days they were booked for and the amount paid.

FOR CURTAILMENT CLAIMS ONLY (the following additional information is required)

- ☐ GP certificate or letter from the treating doctor to confirm that it was necessary to curtail on medical grounds.
- ☐ The Tour Operator's report into the incident which caused the curtailment (where available).
- ☐ Any flight tickets/boarding passes etc. which confirms the return home journey.

Please Note - scan & photocopies are acceptable, however, we do always encourage you to retain the original documentation in case we require any particular documents to be sent in for inspection or retention. Examples where this would be required are high value claims (for prevention of fraud) where we are required to retain originals for a certain period of time.

Claimant/Contact Details:

Claimant Name: | Claimant Age:

Name of Person handling the claim: (if different to above)

Address for Correspondence:

Postcode: | Tel No:

Email address:

Planned Travel Dates: Outward Journey Date: D D M M Y Y Return Journey Date: D D M M Y Y

Insurance Policy Details:

Name of Travel Insurance:
(e.g. the name of your coach travel provider)

Travel Insurance Policy Number: | Date Insurance Purchased: D D M M Y Y

Medical Screening Reference: *Please enclose the Medical Screening Confirmation – if applicable*

Other Insurance Policies:
Do you hold any other insurance policy that may provide you with additional cover for your claim (e.g. BUPA, etc)? ☐ YES ☐ NO

If yes, please give details

Details of Claim:

Please describe the nature of the injury/illness

Date of accident/onset of illness D D M M Y Y Place of accident/illness (country)

If you are claiming because of illness - Have you previously suffered from this condition? ☐ YES ☐ NO

If yes, please provide details:

If you are claiming because of an accident - Circumstances of accident:

Were you admitted as a hospital inpatient: ☐ YES ☐ NO

If so: Date admitted / / Time admitted / / Date discharged / / Time discharged / /

Were any member of your party or family required to attend to you whilst in hospital? ☐ YES ☐ NO

How were you transported to hospital:

The approximate distance between hospital and resort:

Medical Costs - if you were treated as an inpatient or outpatient:

Were the Medical Assistance Company contacted? ☐ YES ☐ NO

If Yes, please show date & time of initial contact and their reference: Date / / Time Ref

If No, please confirm why:

MEDICAL ACCOUNTS ALREADY PAID (please attach separate list if necessary)

Bill Number (If you have more than 1 bill, please number them for ease of reference)	Description Of Bill	Date Paid	Amount Paid (and currency used)	Did you use a GHIC? (UK Global Health Insurance Card) this may reduce your excess
1		DD MM YY		YES / NO
2		DD MM YY		YES / NO
3		DD MM YY		YES / NO
		TOTAL:		

OUTSTANDING MEDICAL ACCOUNTS STILL AWAITING PAYMENT (please attach separate list if necessary)

Bill Number	Description Of Bill	Invoice Amount (in local currency)
1		
2		
3		
	TOTAL:	

Do you expect any further Medical Invoices? ☐ Yes ☐ No ☐ Don't Know

Will the Insurance Company be invoiced direct for any medical treatment? ☐ Yes ☐ No ☐ Don't Know

If Yes / Don't Know to either of the above, please provide details:

ADDITIONAL RETURN HOME / TRANSPORT COSTS (if applicable)

Expenses Incurred	Description of Expenses (e.g. Taxi cost from Apartment to Airport)	Amount Paid
Flight Costs		
Taxi Costs		
Other		
	TOTAL:	

SKI PACK COSTS (if applicable)

	Period you were unable to use your Ski Pack (Please show full days only)	Total Amount Paid
Ski Pass	From: DD MM YY To: DD MM YY	
Ski / Equipment Hire	From: DD MM YY To: DD MM YY	
Ski Lessons	From: DD MM YY To: DD MM YY	

Curtailment Claims Only (only complete the following section if you had to curtail your holiday / trip)

Date you were advised to curtail your trip: D D M M Y Y

Who advised that curtailment of your trip was necessary?

Names of people claiming under this insurance:

1. 2. 3.

4. 5. 6.

Curtailment due to Medical Reasons:

Description of injury/illness causing Curtailment:

Name of Person causing the Curtailment:

Your relationship to them:

PJ Hayman & Company Limited may need to contact the GP who has completed the medical certificate, should further clarification be required. Please confirm that this is in order by providing the patient's signature below.

Signature Of Patient:

Name of GP:

Address of GP:

Curtailment due to Other Reasons:

Please state reason

- If curtailment is due to any other reason, we may request additional independent confirmation of the need to curtail.

Cost of the Holiday/Trip:

Total Amount Paid (less insurance premium) £

Date Paid D D M M Y Y

Amount Refunded (if any) £

Total Amount Claimed (proportionate cost) £

Data Protection Notice

Personal Information – means information that identifies and relates to you or other individuals (i.e. your dependants). By providing Personal Information to P J Hayman & Company Limited you give us permission for its use as described below.

Full details about our use of Personal Information can be found in our full Privacy Notice at: www.pjhayman.com/documents/PJH_Privacy_policy.pdf or you may request a copy using the contact details provided.

When providing **Personal Information** about another individual to us, you confirm that you are authorised to provide it for use as described below.

Types of Personal Information we may collect and why:

Depending on our relationship with you, **Personal Information** collected may include:

- identification and contact information,
- payment card and bank account,
- credit reference and scoring information,
- sensitive information about health or medical condition,
- and other **Personal Information** provided by you.

Personal Information may be used for the following purposes:

- Insurance administration, (communications, claims processing and payment)
- Decision-making on provision of insurance cover and payment plan eligibility,
- Assistance and advice on medical and travel matters,
- Management and audit of our business operations,
- Prevention, detection and investigation of crime, (fraud and money laundering)
- Establishment and defence of our legal rights,
- Legal and regulatory compliance, including compliance with laws outside your country of residence,
- Monitoring and recording of telephone calls for quality, training and security purposes.

Sharing of Personal Information:

Personal Information may be shared with our group companies, Brokers and other distribution parties, Insurers and Reinsurers, Credit Reference Agencies, healthcare professionals and other service providers. **Personal Information** may be shared with other third parties (including government authorities) if required by law. **Personal information** (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

Security and retention of Personal Information:

Appropriate legal and security measures are used to protect **Personal Information**. All third party service providers are also selected carefully and required to use appropriate protective measures. **Personal Information** will be retained for the period necessary to fulfil the purposes described above.

International transfer:

Due to the nature of our business, **Personal Information** may be transferred to parties located in other countries with different data protection laws than in your country of residence.

Data requests:

To request access or correct inaccurate **Personal Information**, or to request the deletion or suppression of **Personal Information**, or object to its use, please email: customerservices@pjhayman.com and mark for the attention of the Data Controller, or write to Data Controller, The Old Theatre, Stansted House, Rowlands Castle, Hampshire PO9 6DX.

DECLARATION

I declare that the whole of the statements made and any other supplementary statements forming part of this claim are true in every respect and understand that a false declaration may invalidate my claim and could result in prosecution. I give permission for my **Personal Information** to be used and shared in the ways described above. I confirm that I will not provide any **Personal Information** about another person without that person's permission.

Customer Declaration - to be completed by ALL persons claiming aged over 16

P J Hayman & Company Limited, agents and business partners may contact anyone who can give them information relevant to my claim.
I/ We confirm that the information that I/ we give is true and if any of the information given by me/ us (or anyone on my/ our behalf) is incorrect, I/ we agree that such inaccuracy may cause me/ us to forfeit my/ our rights under the policy.
In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.
Payments: Subject to admission of liability, we will make payment in favour of the claimant (aged over 16) as detailed above but if an alternative payee is required please state below.
I/ We have read and fully understood the above declaration.

Insured Name	Signature	Date of Birth	Date of Signature

Access to Medical Reports Act 1988

You are responsible for arranging completion of the separate Medical Certificate provided. However, if on receipt of that Medical Certificate it is deemed necessary to obtain a further medical report from the doctor concerned in relation to this claim we will obtain further information from the doctor ourselves. In that event, before we can write to the doctor we require consent from the patient or next of kin as appropriate. Before signing the consent form, the patient concerned should read the following summary of their rights under the Access to Medical Reports Act 1988;

a) You can withhold your permission but if you do we will be unable to proceed with your claim if further information is required
b) If you wish to see the medical report, you must indicate on the claim form and contact your doctor within 21 days about arrangements to see the report. Whether or not you wish to see the report before it is sent to us, the doctor must let you see a copy for up to 6 months after it is supplied, if you ask
c) You can ask the doctor if he/she will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement you may append your comments

Your doctor can in certain circumstances withhold the report from you, or any part of it.

Consent to Obtain a Medical Report to be completed by the Patient or Next of Kin (as appropriate)

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to P J Hayman & Company Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to P J Hayman & Company Limited.

Patient Name:	Signature (Patient):	Date:

Doctor's Name:

Address:

Settlement Method - Claims are paid by Bank Transfer.

Please complete the below to prevent us asking for this at a later date:

Bank Name/Address

Name on Account

Sort Code

Account Number

Additional Information: