22-26 Prospect Hill
Galway, Ireland
traveldept@mapfre.com

TRAVEL INSURANCE CLAIM FORM

	Claim Reference Number:
	Policy Number:

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS

CLAIMANT DETAILS

NAME OF LEAD CLAIMANT: Title: ____ Forename: _____ Surname: _____

Sex: M/F D.O.B. _____ Occupation: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE: Home _____ _____ Work _____ _____ Mobile _____ _____

LEAD POLICYHOLDER NAME: Title: ____ Forename: _____ Surname: _____

Claimant's Relationship to Lead Policyholder: _____

HOLIDAY/TRIP DETAILS

Tour Operator: _____ Travel Agent: _____

Destination/Country: _____

Date holiday booked: _____

Departure Date: _____ Return Date: _____

PREVIOUS CLAIM DETAILS:

Have you made an insurance claim in the past 5 years? **YES/NO**

If YES please provide details:

Date	Type Of Claim	Amount Claimed	Company

DECLARATION: Insurers and their agents share information to prevent fraud and for underwriting purposes. This document, information provided when taking out the Policy and relevant facts form the basis of your claim and may be shared or used for audit purposes. It is a criminal offence to make a fraudulent claim. We investigate all cases and any person suspected of fraud is reported to the Police/Gardai with whom we always cooperate in effecting a prosecution. I/We understand that you may seek information from other insurers to check that the information provided above is truthful and that details of this claim can be used for audit purposes. I/We understand that you may request information from medical providers abroad in relation to a claim where medical advice was sought. I/We declare that to the best of my/our knowledge and belief that all the information I/We have given is correct. I/We have not withheld any information connected with this incident and agree to provide any further information or documentation as may be required. I understand that the insurer does not admit liability by the issue of this form.

ALL PERSONS CLAIMING MUST SIGN BELOW:

Name (please print)	Signature	Date

CANCELLATION

Please detail the circumstances giving rise to this claim: _____

_____

Name of Person whose ill health gives rise to this claim: _____ Relationship to Claimant: _____

Did you make a medical declaration prior to Booking your Trip/Purchasing your Insurance: YES/NO

If 'Yes', please provide reference number: _____

When were you advised to cancel the holiday? _____

If claim is due to medical reasons, may we contact the GP directly if any point needs clarifying? **YES/NO**

If YES please sign: _____

Name and Address of GP: _____

_____

Please list all persons claiming and their relationship to the person to whom the Medical Certificate applies:

Name	Relationship	Age		Name	Relationship	Age

For Cancellation: When did you advise the tour operator/travel agent to cancel the holiday? _____

Total holiday cost: _____

Discounts Received: _____

Refunds Received: _____

Total Claimed: _____

Date Expense Incurred	Description	Foreign Currency Amount	Rate of Exchange	Bill Paid - Yes/No	Office Use Only

CHECKLIST: Please ensure you sign the declaration overleaf and enclose the following ORIGINAL documents as applicable:

All Claims:

Booking Invoice/Travel Tickets showing breakdown of travel and accommodation costs YES/NO

Certificate of insurance (Photocopy only) YES/NO

Medical Certificate completed by usual treating GP specifying diagnosis YES/NO

Death Certificate (if applicable). (This will be returned on completion of claim) YES/NO

For Cancellation:

Cancellation Invoice(s) showing full cancellation charges for Flights and Accommodation YES/NO

(Please obtain from the Tour Operator where appropriate).

Payment Details (Please tick the appropriate form of payment):

Cheque:_____ Bank Transfer:_____

If you wish to receive payment by bank transfer, please supply us with the following information;

(NB Payment cannot be issued by bank transfer unless all below details are provided)

Bank Name and Branch:_____

Account Holder's Name:_____ Account Number:_____

Sort code:_____ IBAN Number:_____

MEDICAL CERTIFICATE – 111015567

To be completed by the USUAL TREATING GENERAL PRACTITIONER of the person whose illness/injury/death gives rise to the claim. Any charges incurred for the completion of this certificate are NOT refundable under the terms of the insurance policy

Name of person to whom this certificate applies: _____ D.O.B. _____

Are you his/her usual treating GP? _____ If YES, for how long? _____

At the latter of either the time the policy was issued, or the holiday was booked (please ask claimant), were you aware of any medical condition which could give rise to a claim: _____

If YES, please outline details: _____

_____

Please describe the CONDITION which gives rise to this claim: _____

When did the patient first consult for this condition? _____

When did you recommend cancellation/curtailment of the holiday? _____

Has the patient been referred to a Consultant/Specialist/Hospitalised in the last 3 years?_____

If YES, please outline details including dates and condition for which he/she was referred:

_____

_____

Please provide details of consultations in the **3 years** prior to the inception of the insurance:

(NB - **Please complete this section in full as it may result in the document being returned if all details are not provided)**

Date of Consultation	Reason for Consultation	Medication Prescribed

Was the patient on a waiting list/awaiting results for any tests/treatments or consultation(s) at the time of inception of the insurance?_____ If YES, please provide details: _____

Had the patient received a terminal prognosis at the time of inception of the insurance?_____

If claim is related to Pregnancy:

Date Pregnancy confirmed: _____ Estimated Due Date: _____

Medical condition associated with pregnancy, which necessitates cancellation:

_____

Doctor's Declaration:

I certify that the reason for this claim was due only to the medical reasons stated above and, in the case of a claim for cancellation, that cancellation was medically necessary.

Doctor's Name (please print) _____ Doctor's Official Stamp:

Signature: _____

Qualifications: _____

Date: _____