Notification Claim Form

Once completed, please return your claim form to:

Intana
Sussex House
Perrymount Road
Haywards Heath
West Sussex
RH16 1DN

Thank you for notifying us of your claim.

Please complete this claim form and return it to Intana as soon as possible.

Please write in BLOCK CAPITALS.

Please provide full supporting documentation to avoid delays in processing your claim.

Company Details (The Assured)

Company Name: _____

Company Address: _____

_____

_____

_____

Postcode: _____

Email address: _____

Telephone Number: _____

Fax Number: _____

Company Contact Name: _____

Claimant Details (The Insured Person)

Title	Full Name(s)	Date of Birth	Position Held

Notification Claim Form

INTANA

Claimant Address: _____

_____

_____

_____

Postcode: _____

Email Address: _____

Telephone Number: _____

Fax Number: _____

Country of Residence: _____

Certificate Number: _____

Insurance Broker/Employer: _____

Travel destination:

Country: _____

Resort: _____

Hotel: _____

Departure Date: ___ /___ /___

Return Date: ___ /___ /___

Purpose of trip: Business ○ Pleasure ○

If Business: Clerical ○ Manual ○

If Manual please provide details of nature of work: _____

_____

_____

_____

Notification Claim Form

If your claim is agreed, please complete the payment details below:

Bank account (UK bank accounts only):

Bank Name: _____

Branch: _____

Bank Sort Code: _____

Account Number: _____

Account Holder: _____

Type of Account (Premier, Gold, Platinum etc): _____

Medical Expenses and Curtailment Claim Form

INTANA

Please TICK ☑

Illness ○ Injury ○

1. Date and time illness/ injury occurred: ___ /___ /___ : _____

2. Country where illness or Injury occurred: _____

3. Full description/ diagnosis of illness or injury:

_____

_____

_____

_____

_____

4. Previous Medical History

Have you suffered from the condition that has resulted in the submission of this claim, or any related condition prior to purchasing insurance or booking your holiday or prior to travelling? Yes ○ No ○

Please have your General Practitioner complete the attached medical certificate

5. Hospital/ clinic details where treatment was provided:

Name: _____

Address: _____

_____

Telephone number: (If known) _____

Name of treating doctor: (If known) _____

6. If you were an inpatient please complete the following

Date of admission: ___ /___ /___

Medical Expenses and Curtailment Claim Form

INTANA

Date of Discharge: ___/___/___

Did you contact the Medical Assistance Company as stated on your policy: Yes ◯ No ◯

If you answer **NO**, then please provide a written explanation as to why the medical assistance company was not contacted:

_____

_____

If Yes, please confirm the date of your first call: ___/___/___

Person spoken to and reference number:

_____

Did you take your EHIC?: Yes ◯ No ◯

Was it presented to the doctor/hospital?: Yes ◯ No ◯

Do you hold any private medical insurance e.g. BUPA, PPP etc? Yes ◯ No ◯

If Yes, please confirm the provider, policy number and address of the insurer:

_____

_____

Medical Expenses and Curtailment Claim Form

INTANA

Please list Medical Expenses claimed:

Please list expenses being claimed and treatment received	Currency and amount paid	Receipt attached	State to whom payment should be made
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	

Curtailment- Please complete this section ONLY if you returned to your home and address earlier than scheduled:

Reason for curtailment:

Illness ○ Injury ○ Illness/ injury or death of relative ○ Other ○

Reason for curtailment:

If curtailment is due to illness/ injury or death of someone not on your policy please confirm your relationship to them:

Date on which you returned: ___/___/___

Number of complete days unused:

Were you accompanied? Yes ○ No ○

Medical Expenses and Curtailment Claim Form

If Yes, by whom?:

Was the airline/train company/ ferry etc contacted to re-arrange travel dates?: Yes ○ No ○

Please complete the table below and list any additional expenses incurred in returning home:

Please list expenses being claimed and treatment received	Currency and amount paid	Receipt attached	State to whom payment should be made
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	
		Yes ○ No ○	

Yes ○ No ○

Medical Expenses and Curtailment Claim Form

Please complete this form as a requirement of the DWP to enable us to obtain a partial reimbursement of medical costs incurred.

Disclaimer

Claim reference No:

I hereby consent to Intana seeking reimbursement of medical expenses paid by them arising out of the medical treatment received in:

Country	
On/from (date)	
Nationality	
National Insurance No. / National Health Service No.	
Date of Birth:	

Signature: Do not use block letters

Date:

Full name of person signing disclaimer

Dependent details (if applicable)

Name:	
Date of Birth:	
National Insurance No.	

Medical Expenses and Curtailment Claim Form

Do you hold any form of bank account/ credit card that offers you complimentary travel insurance that covers the circumstances surrounding your claim?
If **YES**, please confirm the following:

Card number: _____

Issuing Bank: _____

Card Type (Gold, Platinum, Premier): _____

Has a claim to a third party been submitted? Yes ◯ No ◯

If **YES**, please provide details: _____

_____

Is there any other relevant policy that may cover the circumstances surrounding your claim? Other policies, Barclaycard, Amex Yes ◯ No ◯

If **YES**, please provide details: _____

_____

If the claim is in relation to injury please confirm the following:

1. An outline of the circumstances giving rise to the accident

_____

_____

_____

2. If a third party was involved the name and address of the Third Party and their insurance details if known

_____

_____

_____

Medical Expenses and Curtailment Claim Form

3. In the event that you are pursuing a claim for damages against a Third Party please provide the name and address of any solicitor who may have been appointed and their reference number

4. If no Third Party was involved please clarify who or what was at fault and why

If your claim is agreed, please provide your bank details below for payment:

Confirm payee name:

Bank Name:

Bank Address:

Bank SWIFT Code:

Bank IBAN:

Account Number:

Sort Code:

Account Holder:

Type of Account (Premier, Gold, Platinum etc):

Declaration: IMPORTANT- Failure to sign will result in your claim form being returned. I/we declare that the above statements are true and correct to the best of my/our knowledge and belief. I/we have not withheld any information within my/our knowledge connected with this claim. I/we agree to provide the insurer with any further information as may be reasonably required. I/we understand that the insurer does not admit liability by issue of this form. **WARNING – the making of a fraudulent or knowingly exaggerated claim is a criminal offence. We investigate all cases and any person suspected of fraud is reported to the police with whom we always co-operate.**

DATA PROTECTION ACT

Medical Expenses and Curtailment Claim Form

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and may be shared with other organisations for this purpose. I/we understand that you may ask for information from other organisations to check the answers I/we have provided.

IMPORTANT

In the event of a third party being liable, all rights in this matter are subrogated to the travel insurance underwriters or their agents on all settlements of this claim.

Signature: _____ Date: ___/___/___

Medical Certificate

To be completed by medical practitioner Please use BLOCK LETTERS

To be obtained at your expense from the patients General Practitioner in all cases of Curtailment or Cancellation Costs resulting from injury, illness or death.

Important: The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries.

1. Name of the Patient: _____

Date of birth: ___/___/___

2. Are you the patient's usual GP? Yes ◯ No ◯

If **YES**, for how long? _____

If **NO**, please provide full details of the patient's usual GP:

_____

_____

3a. Please give a precise diagnosis of the illness or injury or cause of death:

_____

_____

b. On what date did the patient first consult you with symptoms of this condition? ___/___/___

4. Date of the onset of the illness or injury: ___/___/___

5. Date tests prescribed: ___/___/___

6. Date tests carried out: ___/___/___

7. Date condition diagnosed: ___/___/___

8. Date referred to specialist: ___/___/___

9. Name and address of specialist/surgeon: _____

_____

_____ Postcode: _____

10. Has the patient received a terminal prognosis? Yes ◯ No ◯

If **YES**, please provide date and prognosis: ___/___/___

_____

Medical Certificate

11. Have you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in question 3a? Yes ◯ No ◯

If **YES**

a. State the diagnosis of the previous illness/injury

b. Advise the date of the occurrence of the pervious illness/injury and advise what treatment/ medication was prescribed

c. Is the patient receiving any medical advice, treatment or medication for this condition or any similar/ related conditions? Yes ◯ No ◯

If **YES**, please provide details:

d. Please list all active medical conditions, date of diagnosis and details of medication, if any:

12. Has any other Medical Practitioner treated this patient for the same/ similar/related illness or injury as described in question 3a? Yes ◯ No ◯

If **YES**, please supply the name and address of the Doctor:

Postcode

13. Has the patient received in patient treatment for any conditions in the last 24 months? Yes ◯ No ◯

If **YES**, please provide details of treatment and when: ___/___/___

Medical Certificate

14. Pregnancy Only

    a. Date of LMP: ___/___/___

    b. Date of pregnancy confirmed: ___/___/___

    c. Estimate date of confinement: ___/___/___

    d. Exact medical condition within pregnancy:

_____

15. Was the claimant required to cancel the travel arrangements solely due to the condition described in question 3a?

Yes ◯ No ◯

16. On which date was it recommended that the patient cancel their travel arrangements? ___/___/___

17. If the dates in answer 7 and 16 differ, please provide explanation:

_____

_____

_____

18. Had the patient planned to travel against your prior advice? Yes ◯ No ◯

If **YES**, please provide details:

_____

_____

_____

I certify that the statements contained in this Medical Certificate are true and correct

Doctor's Signature: _____ Date: ___/___/___

Doctor's name: _____

Qualification: _____

Postal address: _____

Medical Certificate

Postcode:

Business phone number:

Fax number:

Mobile phone number:

Email address:

Practice Stamp: