

## **CLAIM FORM**

## FREQUENTLY ASKED QUESTIONS

### Q: How long will it take for me to receive a response to my claim?

**A:** We are committed to providing a quality service - you should expect to receive a response from us within three weeks. To avoid delays please ensure that you provide us with all the relevant documentation required to process your claim.

### Q: Do I need to send original documentation with my claim?

**A:** The only original documentation we require are invoices and receipts required to support your claim, although we also suggest that you keep photocopies of every item you send us. Please note all costs incurred obtaining documentation should be borne by the claimant.

### Q: I do not have all the documents you require; can I proceed with my claim?

**A:** It is a requirement of your policy that you provide full details when making a claim. You can still submit your claim with an accompanying letter explaining the reasons why you are unable to supply the required documents, but without all relevant documentation we cannot guarantee that the claim can be processed.

#### Q: Where can I get my Insurance Certificate/Booking invoice from?

**A:** If you are not already in possession of these documents you can request them directly from the travel agent where you booked your trip. If you purchased your insurance with an alternative provider you will need to contact them directly.

### Q: How will claim payments be made?

**A:** Payments can be made by cheque or BACS transfer, which takes much less time - please complete the claim form accordingly. It will be made the currency your policy is issued in.

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## Q: I'm not satisfied with the settlement; what should I do next?

A: We suggest that you first refer to your policy as limits, exclusions, depreciation or excesses may apply. If you have been sent a Claim Settlement Breakdown sheet this may provide further information. If you remain dissatisfied with the settlement you should contact our Travel Claims Unit. Alternatively you can write to us at the UK or Irish addresses below - please mark 'Appeal' on the envelope. The claim will be reviewed and you will then be advised of your further options.

### Q: Where do I write to?

**A:** Please ensure that all documentation includes your Claim Reference Number and is sent to the relevant address below:

#### **UK Residents**

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

#### **Irish Residents**

Intana
Collinson Insurance Services Ltd
Claims Department
IDA Business Park
Athlumney
Navan
Co. Meath



# **Guidance Notes for Personal Accident Claims**

Please submit originals of all of the following - photocopies are not acceptable. We recommend that you keep copies of everything you send us for your own records										
	The Insurance Certificate (Annual Certificates will be returned) or, if the insurance was purchased on the internet, a copy of the e-mail showing the insurance details.									
• The	The booking invoice for your trip									
• Wh	Where the claim follows death -									
	The death certificate									
	o Grant of Probate or letters of administration									
	Coroner's report where applicable									
	<ul> <li>Copy findings of inquest if applicable</li> </ul>									
	The Police Report if applicable									

## Please read these important notes:

- Upon receipt of the completed medical declaration section of the claim form, we
  may require additional medical information. Please also be advised that any costs
  incurred for the requested medical information are to be borne by you as the
  claimant, as per the terms and conditions of your policy.
- Please note that the policy does not offer compensation for all types of injury; it pays benefit only in the event of the specific and severe types of trauma listed. Please refer to your policy for full details.
- Claim payments can be made by cheque or BACS transfer, which takes much less time – please complete the claim form accordingly. The claim payment will be made in the currency of your residency.

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Claim Reference Number	

## **PERSONAL ACCIDENT**

Claim Form Please complete in **BLOCK** capitals ensuring all relevant fields are completed Intana, Collinson Insurance Services Ltd, Claims Department, IDA Business Park, Athlumney, Navan. Co. Meath. Ireland **CLAIMANT DETAILS** Title Mr/Mrs/Ms/Miss/Other Surname First Name Date of Birth DD / MM / YYYY Address Home Telephone No Work Telephone No Mobile Telephone No Occupation **Email Address** Preferred means of contact: Telephone Email Postal **POLICY DETAILS** Policy Number Date of Purchase DD / MM / YYYY Purchased through: Lead Name on Policy (If different from claimant) Relationship to claimant Is policy / lead name address different to claimants: Yes No If Yes, please provide below: Postcode **OTHER CLAIM DETAILS** Have you submitted any other claim form to us in conjunction with this claim? Yes If yes claim reference number

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INCIDEN.	T DETAILS										
Incident da	ite					DD / MM / YYYY					
Describe the circumstances surrounding the claim, including all relevant dates, places and what you / the injured person were doing at the time.											
Date docto	r first consulted					DD / MM / YYYY					
Were the p	police involved?				Yes	No					
If yes, plea	se provide their repo	ort or the na	me, addre	ess and teleph	one number	of the police station ir	nvolved:				
Witness na	me and address who	ere available	j:								
Please des	cribe as fully as poss	ible the natu	ure of the	injuries sustai	ned:						
	, ·										
If your clain	m relates to any of the	he below ple	ease tick a	nd provide th	e requested a	additional information	:				
Special Spo	orts		State sp	ort / activity							
Winter Spo	orts	State	winter sp	ort / activity							
	inter sport / activity					On pis	ste	Off piste			
	/ the injured person Hour Emergency Ser		d did you	/ he / she con	tact the	Y	'es	No			
Date	DD /	MM / YYYY	Time	H H : N		Medical Claim Referen (if appropriat					

MEDICAL DECLARATION			
claim. Any fee charged for the	leted by the regular medical practitioner of the person whose dealle completion of this form must be paid by the claimant.  K capitals and validate with surgery stamp. Please complete all quest		the reason for this
Name of Patient			
Are you the patient's regular	Yes	No	
If no, please state relationship			
Precise nature of injury / caus	e of death / diagnosis and causation (if limb or eye, please state left o	or right):	
Date of Illness / injury / death	?		DD / MM / YYYY
What treatment was received?			
When did the patient first consult you with regard to this condition?			
Is there anything in the medic or contributed to the level of If Yes, please provide details:	al history that could have caused disability, injury or death?	Yes	No

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Does the disability prevent th undertake any type of work? If Yes, please provide details:	e patient from being able to		Yes	No
Tres, pieuse provide details.				
If so, is this situation likely to	change or improve?		Yes	No
Was the patient on medicatio If Yes, please provide details:	n?		Yes	No
Signaturo(c)		Data		
Signature(s)		Date		DD / MM / YYYY
GP Stamp	(CERTIFICATES CANNOT BE ACCEPTED WITHOUT THE AF	PROPRIATE DOCTOR'S STA	MP)	

ACCESS TO MEDICAL RECORDS & REPORTS
Your rights – Please read carefully
Your consent is needed before we can apply for your medical history and / or a medical report from your doctor, or other medical practitioner.
In the event that you do not consent, we may be unable to process your claim, or continue with benefits for a claim already in existence. If you do consent, then you have a choice whether or not to see the report before your doctor, or other medical practitioner forwards it to us.
If you indicate below that you wish to see the report, you will have twenty-one (21) days after you have received our notification in which to contact your doctor, or other medical practitioner. If you indicate below that you do not wish to see a copy of the report but later change your mind, you are entitled to request a copy directly from your doctor, or other medical practitioner, for up to six (6) months after it has been sent to us. If you are supplied with a copy of the report your doctor, or other medical practitioner is entitled to charge you a reasonable fee to cover costs. In addition, if your doctor, or other medical practitioner, spends time with you discussing your report there is an additional entitlement to charge a fee to cover the time involved as this would not fall within the NHS terms of service.
Your doctor is not obliged to let you see any part of the report if it is felt that it would cause you harm, would indicate his intentions towards you or would reveal the identity or details of another person who is not a professional involved in your care. Your doctor, or other medical practitioner, will inform you if this applies to sections of your report and you may ask to see the remaining parts. If the whole report is affected then it will not be forwarded to us without further consent.
You are entitled to write to your doctor, or other medical practitioner, and request that your report be amended if you consider it, or any part of it, to be incorrect or misleading. If your doctor, or other medical practitioner, is not prepared to amend your report, a statement of your views can be attached to it.  Please tick the appropriate box, complete the form below (where applicable) and return it to us.  I wish to see the report before it is sent. I do not wish to see the report before it is sent.
I wish to see the report before it is sent.
Please complete your details
Signature(s)  Date  Date
Print Name

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SETTLEMENT DETAILS																						
Claims payments made by BACS transfer or other electronic banking system can be made and credited to your account more quickly than a cheque.																						
By entering your bank account details, you confirm that Intana has your full authority to remit monies directly to that account by the BACS or other electronic banking system. You also accept that, providing payment remitted to the bank account designated by you, Intana shall have no further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.																						
Name of account holder																						
Type of current account								e.g. Platinum / Gold / Premier														
Nam	e / Add	lress o	f Bank	/ Build	ding So	ociety	′															
IBAN																						
SWIF	T BIC																					
Pleas	e note	if the		details	provi	ded a	om shou are illegi ded.							e, pa	aymer	nt will	be m	ade b	y ched	que p	ayable	e to the
THIE	RD PA	RTY A	AUTHO	ORIT	Y																	
Do yo	ou requ	uire a t	hird pa	arty to	hand	le this	s claim c	n yo	our be	ehalf							Yes				No	
If yes	, pleas	e com	plete th	he bel	OW																	
							ated Thi															
			im on N ress:	-	Our be	half a	nd agre	e th	at all	comi	munic	ation	s in re	spec	t of th	ne cla	m wil	l be so	olely t	hroug	the	m at
Po	stcode	9								Т	eleph	none N	Numb	er								
DEC	LARA <sup>.</sup>	TION																				
I / We confirm that the facts stated in this form to be true and accurate to the best of My / Our knowledge. I / We understand that the information provided in relation to this claim may be shared with other insurers or financial institutions for the purposes of dealing with this claim and eliminating insurance fraud. I / We give authority to the insurers and their representatives to contact My / Our Medical Practitioners for any additional information.																						
I / We confirm that I / We give authority for you to approach any third party who holds information relating to the incident giving rise to this claim, I / We hereby authorise any such third party to release such information to you to assist in the investigation and resolution of My / Our claim.																						
I / We hereby grant Intana (as agent for the underwriter) full rights of subrogation in respect of any payments made on My / Our behalf. I / We further agree to fully co-operate with any such recovery efforts from liable third party or parties.																						
			-			-	our age			-	y to d	eal w	ith the	e clai	m, we	e will	not b	e able	to dis	cuss	any d	etails of
Signa	ture(s)			Х	<u>.                                      </u>								X			Date				DD /	NA NA /	VVVV