INTANA

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 provide a quality service, our claims team will review the documentation supplied and will contact you as soon as possible. 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 original documentation we require are invoices and receipts required to support your claim and we suggest that you keep photocopies of every item you send us. Please note all costs incurred obtaining documentation should be borne by you.

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?
A: If you are not already in possession of these documents you can request them directly from wherever you purchased the Policy. Failing this, please let us know and we may be able to help obtain this.

Q: Where can I get my Booking Invoice?
A: You can obtain this from the Travel Agent, Tour Operator, or if you have booked directly, a copy of the email / invoice from the Travel / Accommodation Provider.

Q: How will claim payments be made?
A: Payments can be made by BACS transfer. Please complete the claim form accordingly. It will be made in the currency your policy is issued in.

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

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Q: I'm not clear on how settlement has been reached; 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 remain unclear with the settlement you should contact our Travel Claims Unit. Alternatively you can write to us at the address provided on the Claim Form – please mark 'Appeal' on the envelope. The claim will be reviewed and you will then be advised of your further options. If you are still not happy with the outcome you may then take the issue further as a formal complaint.

Q: Where do I write to?

A: Please ensure that all documentation includes your Claim Reference Number and is sent to the relevant address provided on the Claim Form.

Guidance Notes For Curtailment (Early Return) Claims

Please submit originals of the following (photocopies are not acceptable, but we would suggest that you may wish to keep a copy 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 booking invoice for your trip to confirm the full costs, deposits paid and date of booking ☐
- Evidence of any refund from the travel provider(s) ☐
- Correspondence received in respect of any medical declaration ☐
- Correspondence from your tour operator in confirmation of the total cost of the unused portion of your holiday (if available) ☐
- If the claim is due to bereavement, we will need to see the death certificate which will of course be returned ☐

Please read these important notes:

In the event of Curtailment or Trip Interruption, You must contact us first and allow us to make all the necessary travel arrangements

- When curtailing for medical reasons and or bereavement, it is essential that the medical declaration is completed in full, with each of the specific questions answered. In some cases we will require further medical information. This should be completed by the GP of the person whose illness necessitated your early return - either your own GP or the GP of your relative
  - If the claim is due to bereavement, we will still require this medical information along with a copy of the death certificate
  - If you curtailed your holiday because of your own health, you must also provide documentation from the doctor who treated you abroad, stating why it was medically necessary for you to return home. Failure to provide this may invalidate your claim
- The policy excess as defined in your policy will be deducted from each and every claim per insured person (unless you have paid the excess waiver premium). In some cases your claim may fall under more than one section - consequently more than one excess may be deducted
- Claim payments will be made by BACS transfer, which takes much less time - please complete accordingly. The claim payment will be made in the currency of your residency
- When the claim is settled we will provide a full breakdown of our assessment

Claim Reference Number

CURTAILMENT

Claim Form

Please complete in **BLOCK** capitals ensuring all relevant fields are completed

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

CLAIMANT DETAILS

Surname

Title Mr/Mrs/Ms/Miss/Other

First Name

Date of Birth DD / MM / YYYY

Address

Postcode

Home Telephone No

Work Telephone No

Mobile Telephone No

Occupation

Email Address

POLICY DETAILS

Policy Number

Date of Purchase DD / MM / YYYY

Purchased from:

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

TRAVEL DETAILS

Country of Destination

Date Trip Booked DD / MM / YYYY

Departure Date DD / MM / YYYY

Return Date DD / MM / YYYY

Type of booking: Package Holiday Independent

DETAILS OF OTHER INSURANCES - <u>Failure to provide the information requested below may delay your claim</u>

Some bank accounts and credit cards come with Travel Insurance benefits and if you did have cover of this nature we may seek a contribution from the other company once your claim is settled. A loss that is covered by more than one policy will routinely be shared so each Insurer can keep their premiums as competitive as possible, but the contributing Insurer cannot alter the price of terms of its policy unless there has been a claim direct from a policyholder.

Name of Bank / Building Society

Type of Account — eg Platinum / Gold / Premier

Sort Code

Account Number

Do you or any of the insured party have any other travel insurance that may cover you for this claim? Yes No

Name of Company

Policy Number

NAMES OF PEOPLE INSURED UNDER THIS POLICY

Names of people insured under this policy who curtailed and their relationship to the policyholder

	Name	Date of Birth	Relationship to policyholder	Medical screening reference if applicable
1				
2				
3				
4				
5				
6				

Have you approached your travel agent/tour operator to obtain a refund? Yes No

If yes, please advise amount refunded **£**

Were you able to use your original return tickets? Yes No

If no, please send your original tickets and enclose proof of purchase for new tickets.

CLAIM DETAILS

Additional Travel details. Please state reason for each section of your travel (ensure all receipts and flight tickets are enclosed).

	From	To	Cost £	Reason for travel
1				
2				
3				
4				
5				
6				

Actual return date DD / MM / YYYY   Total number of nights accommodation lost

Total cost of original Trip (excluding ski pack if applicable) £

(Unused accommodation will be calculated on a % basis based on nights of unused pre-booked accommodation. Please forward a booking invoice showing breakdown of accommodation costs).

Winter Sports   State winter sport / activity

Was the winter sport / activity carried out on piste or off piste?   On piste   Off piste

Lessons (per adult) £   Ski Pass (per adult) £

Equipment Hire (per adult) £   Total cost of ski pack (per adult) £

Date ski pack started DD / MM / YYYY

Date ski pack scheduled to expire DD / MM / YYYY

Date and time unable to use ski pass from DD / MM / YYYY   HH:MM

CURTAILMENT DETAILS

Please give full details for the reason for curtailment and attach appropriate written confirmation.

(If the curtailment is for medical reasons you must include written confirmation from the treating doctor abroad that curtailment was medically necessary. If curtailment was due to a person not covered by this insurance, his/her GP must complete the medical declaration for a non-insured person.

Name of treating doctor   Contact Details

Date(s) of consultation

Did you the contact Intana 24-hour emergency service at the time of the incident? Yes ☐ No ☐

Date DD / MM / YYYY Time HH:MM Our Reference

If no, please give a full and detailed explanation of why you failed to contact the emergency service:

(Failure to contact the Intana Emergency Service at the time of the incident may limit the amount of your claim. Please refer to your policy wording for further details).

NON-MEDICAL CURTAILMENT

Reason for curtailment:

Please provide official documentation to support the need to curtail your trip.

MEDICAL DECLARATION FOR AN INSURED PERSON

If this claim is related to a person insured under this policy then please complete this section (Pages 5 & 6). If this claim is due to a close relative, travelling companion who is not insured under this policy or person with whom you intend to stay then please complete the medical declaration for a non-insured person (Page 7).

Name of Patient

Booking Date DD / MM / YYYY Date insurance was purchased DD / MM / YYYY

This section should be completed by your GP in relation to the medical condition which necessitated your claim. Completion by a Hospital, Specialist or Consultant will not be accepted. Any charges incurred to obtain this information are not covered under your policy. Medical Records/Further Medical Information may be requested. (Doctors please write in **BLOCK** capitals and validate with surgery stamp. **Please complete all questions**).

Are you a GP at the patient's regular practice? Yes ☐ No ☐

Were you consulted in relation to the patient's intention to travel? Yes ☐ No ☐ If yes, Date DD / MM / YYYY

State (a) the medical condition(s) or (b) the cause of death, which resulted in this claim.

(a)

(b)

Date of first consultation for the condition(s)? DD / MM / YYYY

Date of diagnosis of the condition(s)? DD / MM / YYYY

Date curtailment was recommended? DD / MM / YYYY

At the time of issue of the insurance (see above) was the patient fit to undertake the planned trip and not planning to travel against the advice of a Medical Practitioner? Yes ☐ No ☐

At the time of issue of the insurance (see above), did the patient have any symptoms for which he/she was awaiting investigations/consultation, and/or where the underlying cause had not been established)? If yes, provide full details below. Yes ☐ No ☐

MEDICAL DECLARATION FOR AN INSURED OR NON-INSURED PERSON CONTINUED

Had the patient been prescribed any medication, received any treatment, or attended any consultations, investigations or follow-ups/check-ups (with any medical practitioner) for ANY medical or psychological conditions **in the 2 years** prior to the date of issue of the insurance?

Date of onset	Specific nature of complaint	Treatment / Medication	Duration

Had the patient **EVER** had any treatment for any cardiovascular or circulatory condition (e.g. heart condition, hypertension, blood clots, raised lipids, stroke, aneurysm)?

Date of onset	Specific nature of complaint	Treatment / Medication	Duration

If the claim arose from a complication of pregnancy please confirm:

(a) the diagnosed complication

(b) the date the pregnancy was confirmed DD / MM / YYYY

(c) the estimated date of delivery DD / MM / YYYY

Signature(s)

Date DD / MM / YYYY

GP Stamp

(CERTIFICATES CANNOT BE ACCEPTED WITHOUT THE APPROPRIATE DOCTOR'S STAMP)

MEDICAL DECLARATION FOR A NON-INSURED PERSON

If this claim relates to a close relative, travelling companion who is not insured under this policy or person with whom you intend to stay then please complete this section (Page 7).

Name of Patient

Relationship to the policyholder

Booking Date DD / MM / YYYY

Date insurance was purchased DD / MM / YYYY

This section should be completed by the Non-Insured person's GP in relation to the medical condition which necessitated the claim. Completion by a Hospital, Specialist or Consultant will not be accepted. Any charges incurred to obtain this information are not covered under your policy. Medical Records/Further Medical Information may be requested. (Doctors please write in **BLOCK** capitals and validate with surgery stamp. **Please complete all questions**).

Are you a GP at the patient's regular practice? Yes ☐ No ☐

State (a) the medical condition(s) or (b) the cause of death, which resulted in this claim.

(a)

(b)

Date of first consultation for the condition(s)? DD / MM / YYYY

Date of diagnosis of the condition(s)? DD / MM / YYYY

Date cancellation was recommended? DD / MM / YYYY

Prior to the date the insurance was purchased did the patient:

(a) require surgery, inpatient treatment or hospital consultation? DD / MM / YYYY

(b) require any form of treatment or prescribed medication? DD / MM / YYYY

Was the patient on a waiting-list for or had knowledge of the need for surgery, inpatient treatment or investigations at any hospital or clinic when the insurance was purchased? If yes, list below

Yes ☐ No ☐

Did the patient receive a Terminal Prognosis when the insurance was purchased? Yes ☐ No ☐

Signature(s)

Date DD / MM / YYYY

GP Stamp

(CERTIFICATES CANNOT BE ACCEPTED WITHOUT THE APPROPRIATE DOCTOR'S STAMP)

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 — eg Platinum / Gold / Premier

Name / Address of Bank / Building Society

Sort Code

Account Number

THIRD PARTY AUTHORITY

Do you require a third party to handle this claim on your behalf Yes ☐ No ☐

If yes, please complete the below

I / We authorise (name of Broker / nominated Third Party) ________

To handle this claim on My / Our behalf and agree that all communications in respect of the claim will be solely through them at the following address:

Postcode Telephone Number

DECLARATION – please tick the boxes to confirm you agree with the following statements:

- ☐ I / We confirm that the information provided in this form and in any accompanying supporting documentation is true, accurate and complete to the best of all claimants' knowledge. In the event of false, inaccurate or incomplete information being provided the Insurer reserves the right to cancel your policy and reject your claim in full or part.
- ☐ I / We confirm that I / We give explicit consent to my data, including up to date medical diagnoses information, being held, used and processed for the purposes described in the Data Protection notice below, including the purpose of undertaking investigations into, and to adjudicate on, my claim (including the length of my hospital stay and the treatment I received).
- ☐ I / We give authority to Intana (as agent of the relevant underwriter) and their appointed representatives to approach any third party who holds information relating to the incident giving rise to this claim, including, but not limited to medical practitioners and hospitals/clinics where the claim relates to a medical condition or injury. Such authority will permit the third party(ies) to release relevant information to Intana to assist in the investigation and resolution of this claim.
- ☐ I / We hereby grant Intana full rights of subrogation in respect of any payments made on behalf of all claimants. I / We further agree to fully co-operate with any such recovery efforts from liable third party or parties and to immediately notify Intana if any lost or stolen property mentioned in this claim form is subsequently recovered.
- ☐ Please confirm that you give your authority for Intana Claims and their appointed representatives to approach any Third party who holds information relating to the incident given rise to this claim. Such authority will permit the Third part(ies) to release relevant information to Intana to assist in the investigation and resolution of this claim

IMPORTANT

Please note that if you do not authorise your agent / third party to deal with the claim, we will not be able to discuss any details of the claim with them due to Data Protection Act regulations.

Signature(s) X ________ X ________ Date DD / MM / YYYY

Data Protection

The information, including sensitive information, (such as health and medical details) that you have provided in this Claim Form, or which you have authorised third parties to provide, will be used by the insurer and their representatives for claims processing, claims auditing (including billing audits), policy administration and customer care purposes. Data may also be used for statistical analyses and the detection and prevention of fraud. We may share your data with trusted third parties who process data or conduct clinical and / or billing audits on our behalf, inside and outside of the European Economic Area. We may also share your data with other insurers to verify your cover, and with state bodies as required by law.