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 Medical Expenses 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 ☐
- All invoices and medical reports in support of your claim ☐
- Any unused flight / ferry / train tickets ☐
- Correspondence received in respect of any medical declaration made in the past ☐

Please read these important notes:

- 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 policy 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
- If you have travelled to an EEA (European Economic Area) country and the provider has accepted your EHIC please advise us accordingly
- If your claim occurred within Europe, please complete the Disclaimer Form on page 3. This will enable any benefit under the European Reciprocal Scheme to be recovered

Claim Reference Number

MEDICAL AND DENTAL EXPENSES

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 - Failure to provide the information requested below may delay your claim

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

Details of private health insurer

Policy Number

IF YOU DO NOT HOLD PRIVATE MEDICAL INSURANCE, PLEASE COMPLETE THE FOLLOWING DECLARATION:

I confirm I do not hold private medical insurance

Signature X X Date DD / MM / YYYY

As part of the European Reciprocal scheme, if your claim occurred within Europe please complete the form below. **If your claim occurred in France, you are required to sign all 'Feuille de Soins' and any Ambulance transport invoices in the box marked 'Signature de l'assuré(e)'.**

Please return all **original** medical invoices with your claim form.

Our Reference

I hereby consent to Intana seeking reimbursement of medical expenses paid by them arising out of medical treatment received on\in: Date DD / MM / YYYY Country Country

I declare that the information given on this form is correct and complete

Signature X X Date DD / MM / YYYY

PLEASE COMPLETE ALL SECTIONS BELOW whether the costs relate to yourself or a child.

Your full name

Your date of birth DD / MM / YYYY

Full name of child (where appropriate)

Date of birth of child DD / MM / YYYY

Your address

Postcode

Child's address (if different from above)

Postcode (where appropriate)

Your nationality

Nationality of child (where appropriate)

National Insurance Number / PPSI (Ireland) in case of child under 16 give parent's N.I number / PPSI (Ireland)

Dates of travel: From (Date) DD / MM / YYYY To (Date) DD / MM / YYYY

Dates of treatment: From (Date) DD / MM / YYYY To (Date) DD / MM / YYYY

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PATIENT DETAILS (if different to claimant or policyholder)

Tick if patient is: Claimant ☐ Policyholder ☐ Other ☐ (if Other please complete the following)

Name of patient: ____________ Patient's date of birth: DD / MM / YYYY

Relationship to policyholder: ____________

INCIDENT DETAILS

Incident date: DD / MM / YYYY

Describe the circumstances surrounding your claim, including all relevant dates and places:

If your claim relates to any of the below please tick and provide the requested additional information:

Special Sports ☐ State sport / activity ____________

Winter Sports ☐ State winter sport / activity ____________

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

Were you injured as the result of an accident? Yes ☐ No ☐

If yes describe the circumstances surrounding your accident, including all relevant dates and places:

Details of any third party involved including contact number / third party insurance details:

Are you pursuing legal action in relation to this claim? Yes ☐ No ☐

If yes, please provide your solicitor's details:

DETAILS OF TREATMENT

Were you admitted to hospital? Yes [ ] No [ ]

If admitted, please provide date and time of admission and discharge below:

Admission date	DD / MM / YYYY	Admission time	HH:MM
Discharge date	DD / MM / YYYY	Discharge time	HH:MM
Name of clinic / hospital		Contact details	

If outpatient treatment, please provide date, time and details of each treatment:

Diagnosis given by treating doctor / hospital:

Did you 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 and your claim is for more than £500, 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).

DETAILS OF EXPENDITURE

List of expenditure / amounts paid by you:

No.	Who you paid	Reason	Cost (inc. currency)
1			
2			
3			
4			
5			
6			
7			
8			

List of outstanding bills still to be paid:

No.	Who still requires payment	Reason	Cost (inc. currency)
1			
2			
3			
4			
5			
6			
7			
8			

Did you pay your policy excess directly to the hospital at the time of treatment? Yes ☐ No ☐

If yes, please include your receipt and confirm the amount £

Did you present a European Health Insurance Card (EHIC) to the doctor / clinic at the time payment was made? Yes ☐ No ☐

DID YOU MAKE A MEDICAL DECLARATION WHEN YOU TOOK OUT THE POLICY?

Yes ☐ No ☐

If yes, please include medical screening documentation.

Health Screening Reference

HAVE YOU EVER BEEN TREATED FOR THIS OR ANY OTHER RELATED CONDITION BEFORE?

Yes ☐ No ☐

If yes, please complete the following Medical Declaration.

MEDICAL DECLARATION

(Please complete if you received inpatient treatment)

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 the medical condition(s) that resulted in the claim

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

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)

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 | | | | | | | | |

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.