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**Medical Expenses Claim Form**

THANK YOU FOR NOTIFYING US OF YOUR CLAIM

PLEASE COMPLETE ALL QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE "N/A"

Name of Policy Holder: UNIVERSITY OF YORK

Policy No: 100003637GPA

Full Name of Claimant: Date of Birth:

Title (Mr, Mrs, Miss, Ms, Dr, Prof): Job Title:

Nationality:

Full Address:

Postcode:

Tel No. (Business): (Home):

Email:

Date on which Travel commenced:

Full Names of other Persons Covered Date of Birth Relationship

1.

2.

3.

**PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS CLAIM FORM**

**ACCIDENT/SICKNESS DETAILS**

Type of Travel: Business/Holiday

Please give exact date and place when injured or taken ill: Date: Place: Country in which incident occurred:

**If accident**, please state fully:-

1. where the accident occurred:
2. how the accident occurred:
3. The injuries sustained:

**If illness**, please state full details of the illness:

Has the Person Covered ever suffered from this illness before? YES/NO

If YES, please give details with relevant dates:

Please state whether the Person Covered was in hospital YES/NO If YES, please state dates of hospitalisation Admitted: Discharged:

Has the Person Covered previously claimed under this or a similar policy? YES/NO

If Yes, please give details:

Is the Person Covered covered under any group private medical scheme i.e. BUPA/PPP

or any similar scheme? YES/NO

If YES, please give name, address, and reference number of the company concerned:

Did the Person Covered use a European Health Insurance Card, E111 or E128 form (if treated within the EU)? YES/NO

Please give name and address of General Practitioner in the UK:

**PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS CLAIM FORM**

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| **DETAILS OF EXPENSE - ALL ACCOUNTS BILLS, RECEIPTS, MEDICAL CERTIFICATES, BOOKING INVOICES, ANY CORRESPONDENCE AND ANY OTHER DOCUMENTS RELATIVE TO THIS CLAIM SHOULD BE FORWARDED TO US** | | | | | |
| **Claimant Name** | **Nature of Expense** | **Name and address of Doctor or Hospital attended** | **Currency being claimed** | **Amount £** | **Paid ()** |
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# PLEASE ENSURE YOU PROVIDE ORIGINAL RECEIPTS/INVOICES FOR ALL EXPENDITURE.

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| **DATA PROTECTION** |
| Information You or the Insured Person supplied may be used for the purposes of insurance administration by Us, its associated companies and agents, by reinsurers and Your intermediary. It may be disclosed to regulatory bodies for the purposes of monitoring and/or enforcing of Our compliance with any regulatory rules/codes. Your and the Insured Person(s) information may also be used for offering renewal, research and statistical purposes and crime prevention. It may be transferred to any country, including countries outside the European Economic Area for any of these purposes and for systems administration. In assessing any claims made, We or Our agents may undertake checks against publicly available information (such as electoral roll, county court judgements, bankruptcy orders or repossessions). Information may also be shared with other insurers either directly or via those acting for the Us (such as loss adjusters or investigators).  With limited exceptions, and on payment of the appropriate fee, You or the Insured Person have the right to access and if necessary rectify information held. |

**DECLARATION**

I declare that the information given is to the best of my knowledge and belief, full, true and correct.

Signed: Date:

**PLEASE ENSURE**

You have completed ALL relevant questions on this claim form.

You have enclosed all requested information/documentation.

You have signed this claim form.

Failure to do so will result in delay in handling your claim.

Please return the completed claim form together with any documentation to:

[insurance-enquiries@york.ac.uk](mailto:insurance-enquiries@york.ac.uk)

**Thank you for fully completing this form.**