General Insurance Co. Ltd.
The Tradition Continues...

**9-11 Bridge Street, Castries,**
**St. Lucia, West Indies.**
**T: 1 (758) 458-8216**
**F: 1 (758) 458-8259**
**E: mcinsure@mandcgroup.com**

# MEDICAL EXPENSES CLAIM FORM

Claim Reference

Please complete this form and return it with all relevant documentation to the above address.
Please do not hesitate to call if you have any queries.

## A. PERSONAL DETAILS

Date of Birth

Occupation

Telephone

Hours of Contact
(at above number)

## B. INSURANCE DETAILS

Policy Name

Date Trip originally Boooked  Travel Dates From  To

Name of Travel Agent, If any  Name of Tour Operator, if any

Hotel Accommodation details  Resort  Country

Do you have Private Medical Insurance?  YES/NO  if YES, please give details

## C. MEDICAL AND EMERGENCY EXPENSES/HOSPITAL BENEFIT

Date of Injury/Onset of Illness  Place of Injury/Illness

Details of Injury/Illness

Circumstances of Accident (if applicable)

Have you suffered from the same/similar condition before?  YES/NO

If YES, please ask your usual doctor to complete the attached medical certificate.
PLEASE NOTE: Any charge made by a doctor for medical reports must be paid by the claimant

If hospitalised, please state dates, Admitted  Discharged

Were you in possession of a valid E111* form ?  YES/NO  (* For travellers in the E.C. only)

If NO, please provide your National Insurance Number

Please sign to give SAS authority to use your E111.  Signature

| Date of Treatment | Expenses Claimed | Amount Claimed | For office Use Only |
|---|---|---|---|

**Total Amount Claimed**

Please continue on a separate sheet if there is insufficient space. Please mark all documents with your claims reference.

State to whom settlement should be paid

**THE FOLLOWING ORIGINAL DOCUMENTS MUST BE SENT WITH YOUR CLAIM FORM FOR CLAIM PROCESSING**

| Item | Enclosed |
|---|---|
| 1. Your original holiday/flight confirmation and/or receipt or deposit receipt | YES/NO |
| 2. Your certificate of Insurance | YES/NO |
| 3. Your travel tickets | YES/NO |
| 4. Hospital, Doctor, Chemist, Dentist receipts for amounts claimed (Non-UK only) | YES/NO |
| 5. Receipts for additional travel and/or accommodation expenses (if applicable) | YES/NO |
| 6. Confirmation of In-patient treatment for hospital benefit claim | YES/NO |
| 7. Any other relevant documentation to support your claim | YES/NO |

**DECLARATION**

I declare that to the best of my knowledge all particulars contained in this form are true and correct.

Signed Date

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# MEDICAL CERTIFICATE

Claim Reference

THIS CERTIFICATE TO BE COMPLETED BY THE USUAL DOCTOR OF THE PERSON WHOSE CONDITION GIVES RISE TO THE CLAIM. ANY CHARGE MADE FOR COMPLETION OF THIS DOCUMENTATION IS THE RESPONSIBILITY OF THE INSURED PERSON AND IS NOT REFUNDABLE BY THE INSURERS.

## CLAIMANT'S DETAILS

Name Date of Birth

NAME OF PATIENT IF DIFFERENT FROM CLAIMANT

PATIENT'S DATE OF BIRTH RELATIONSHIP TO CLAIMANT

PATIENT'S CONSENT FOT THE RELEASE OF MEDICAL INFORMATION

I authorise the medical practitioner named below to release any information required by Insurers or their appointed agents to enable my claim to be processed.

Signed Date

Dear Doctor,
The above named Insured Person has submitted a claim on their Travel Insurance Policy. In order for us to process this claim, we would be grateful if you would respond to the questions below.

How long have you been the patient's usual doctor?

Precise nature of the medical condition/illness/injury/cause of death

Date first consulted for this problem

Was the patient waitlisted for a hospital admission? Please advise dates of waitlist and admission as appropriate

Please advise details of any relevant previous medical history, including any chronic and/or recurring medical problem of a serious nature which has necessitated consultation, medication or in-patient treatment over the last 30 months.

In your opinion was the patient fit to travel as proposed

Had the patient been given a terminal prognosis?

Is the patient pregnant? YES/NO If YES, please give E.D.D.

I, Dr..... confirm that the above information is correct

Signed Qualifications Date

Address

Official Stamp