



**PLEASE WRITE IN BLACK INK AND USE BLOCK CAPITAL LETTERS.  
 ALL SECTIONS MUST BE COMPLETED OR MARKED 'NOT APPLICABLE'.  
 COMPLETE THE CHECKLIST AND ENSURE THAT YOU SIGN THE DECLARATION AT THE END OF THIS FORM.**

POLICY NUMBER			
<b>MAIN POLICYHOLDER DETAILS</b>			
TITLE	FIRST NAME	LAST NAME	
e-MAIL ADDRESS		DATE OF BIRTH (DD/MM/YYYY)	
FULL ADDRESS			
			POSTCODE
CONTACT NUMBER (DAYTIME)		CONTACT NUMBER (EVENING)	
<b>INSURED PERSONS DETAILS</b>			
FULL NAME	DATE OF BIRTH (DD/MM/YYYY)	RELATIONSHIP TO MAIN POLICYHOLDER	I INTEND TO CLAIM ON BEHALF OF: (✓) where applicable
MAIN POLICYHOLDER AS ABOVE			

**ACCESS TO MEDICAL REPORTS ACT 1988** BEFORE YOUR ATTENDING DOCTOR CAN GIVE A MEDICAL REPORT ON THIS CLAIM FORM WHICH IS A REQUIREMENT OF THIS CLAIM, YOU MUST GIVE YOUR CONSENT. BEFORE GIVING YOUR CONSENT, YOU SHOULD BE AWARE OF YOUR RIGHTS UNDER THE ACT WHICH ARE SUMMARISED AS FOLLOWS:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading. If the Doctor does not agree with your request you may attach your comments to the report.

NB: The Doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

**PATIENT DECLARATION**

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to ACE seeking medical information from any Doctor who at any time has attended me concerning conditions which affect my physical or mental health.
2. I authorise such Doctor to disclose such information to ACE.
3. I agree that a copy of this consent shall have the validity of the original.

- I **DO** wish to see the report before it is sent to ACE  
 I **DO NOT** wish to see the report before it is sent to ACE

SIGNED

DATE

**ACCIDENT/SICKNESS DETAILS** - PLEASE PROVIDE A COPY OF YOUR ORIGINAL ITINERARY/TRAVEL DOCUMENTS IF AVAILABLE

Type of Travel: BUSINESS/HOLIDAY \_\_\_\_\_ Date of Trip \_\_\_\_\_

Please give exact date and place where injured or taken ill: DATE \_\_\_\_\_ PLACE \_\_\_\_\_

Was a **European Health Insurance Card (EHIC)** used? YES / NO

If YES please provide details: \_\_\_\_\_

\_\_\_\_\_

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If **accident** please state fully: \_\_\_\_\_

(a) Where the accident occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(b) How the accident occurred: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

(c) The injuries sustained: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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If **illness** please state full details of your illness: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Have you/the claimant ever suffered from this illness before? YES / NO

If YES please give details with relevant dates: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please state whether you/the claimant were in hospital YES / NO

If YES please state dates of hospitalisation: ADMITTED \_\_\_\_\_ DISCHARGED \_\_\_\_\_

Have you/the claimant previously claimed under this or a similar policy? YES / NO

If YES please give details \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you/the claimant covered under any group private medical scheme ie BUPA/PPP or any similar scheme YES / NO

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

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please give name and address of General Practitioner in the UK \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

PLEASE ALSO PROVIDE US WITH A LETTER FROM YOUR/THE CLAIMANTS ATTENDING DOCTOR CONFIRMING IT WAS IN ORDER FOR YOU TO TRAVEL.



**PAYEE'S BANK DETAILS** IF WE APPROVE YOUR CLAIM, WE CAN CREDIT THE MONEY DIRECT TO YOUR BANK ACCOUNT. THIS METHOD IS QUICKER, SAFER AND MORE RELIABLE THAN PAYMENT BY CHEQUE. IF YOU WOULD LIKE US TO DO THIS, PLEASE COMPLETE THE FOLLOWING:-

Name of your Bank/Building Society: \_\_\_\_\_

Bank Sort Code

Address \_\_\_\_\_

Account Number

Name of Account Holder(s) \_\_\_\_\_

Postcode \_\_\_\_\_

**DATA PROTECTION** The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1998. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by ACE European Group Limited and its group companies. It may be held on computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

FOR SECURITY PURPOSES PLEASE PROVIDE A PASSWORD.  
YOU WILL NEED THIS TO ACCESS YOUR CLAIM INFORMATION

PASSWORD: \_\_\_\_\_

**DECLARATION** I DECLARE THAT ALL THE INFORMATION GIVEN IS TO THE BEST OF MY KNOWLEDGE AND BELIEF, FULL, TRUE AND CORRECT.

SIGNED \_\_\_\_\_

DATE \_\_\_\_\_

**CHECKLIST** PLEASE RETURN THE COMPLETED CLAIM FORM TOGETHER WITH ANY ENCLOSURES TO ACE EUROPEAN GROUP LIMITED.

PLEASE ENSURE...

- YOU HAVE COMPLETED ALL RELEVANT QUESTIONS ON THIS CLAIM FORM
- YOU HAVE ENCLOSED ALL REQUESTED ORIGINAL DOCUMENTS (We recommend you retain copies)
- YOU HAVE SIGNED THIS CLAIM FORM

IF YOU DO NOT COMPLETE ALL SECTIONS AND PROVIDE ALL REQUESTED DOCUMENTATION, YOUR CLAIM WILL BE DELAYED.

