EXTRAMILE TRAVEL SCHEME
MEDICAL & OTHER EXPENSES CLAIM FORM

Claim Number: A claim number will be allocated once this form is returned

IN FIRST INSTANCE PLEASE EMAIL THIS CLAIM FORM AND SUPPORTING EVIDENCE TO claims@extramileinsurance.co.uk

Extramile INSURANCE

We may request Hard Copies of all receipts and correspondence in relation to your claim please use the address to the right quoting your Claim Reference Number
We aim to process the initial information in five working days

AICUK Ltd
Office 1&2,
203 &205 The Vale
London
W3 7QS

This claim form is being provided to you as requested in order that you can make a claim for Medical & Other Expenses under the terms and conditions of your travel insurance policy. Please keep a copy of this claim form and other documents for your own records

If the claim relates to tragic circumstances such as a death, please accept our sincere condolences. In this event the name and address of the **CLAIMANT** *(please see question Q01 below)* should relate to the person with whom we should correspond. We regret that it is essential for a death certificate to be provided in these circumstances.

IMPORTANT DOCUMENT CHECK LIST – Please use and complete incomplete information will cause delays We require scanned copies of all supporting evidence to be submitted with the Claim form initially by email to the email address above. We may ask for hard copies of the form and all documentation to be sent by post to our address above		**PLEASE TICK**			
		Enclosed	**Previously Sent**	**Not Available**	**Not Applicable**
CERTIFICATE OF INSURANCE	(or other proof of payment of insurance premium i.e. the Tour Operators booking invoice)				
HOLIDAY BOOKING INVOICE	as issued by the booking Agent & Tour Operator (if applicable)				
ORIGINAL RECEIPTS	for any costs being claimed				
MEDICAL EVIDENCE	to support details of illness or injury				
DEATH CERTIFICATE	(if applicable)				
EVIDENCE OF HOSPITAL ADMISSION AND DISCHARGE	(only applicable if the Claimant was an in-patient in hospital)				
ORIGINAL TRAVEL TICKETS	(i.e. flight coupons/ferry tickets)				
ADDITIONAL TRAVEL TICKETS	(if applicable)				

CLAIMANT DETAILS	
Q01.	Title: First Names: Surname:
Q02.	Date of Birth: / / Present Age:
Q03.	Occupation:
Q04.	Address:
	Post Code:
Q05.	Home Tel: Mob Tel: Work Tel:
	E-mail:

TRIP & INSURANCE DETAILS	
Q06.	Trip booking date: / / Period from: / / to: / / Number of days:
Q07.	Number of people in your party:
Q08.	Trip Country & Destination:
Q09.	Purpose of Trip (Business Travel. Holiday, Student studying abroad etc)
Q10.	If the trip was for Business please describe work being undertaken during the trip
Q11.	Name of the travel / booking agent who issued the policy:
Q12.	Travel Insurance Policy Number (as shown on your Insurance Confirmation Letter):
Q13.	Policy issue Date as found on your Insurance Confirmation Letter ***(very important)***: / /
Q14.	Method of payment for the trip (Delete as necessary): Credit Card / Debit Card / Cheque / Cash/ Other
	If credit / debit card was used please provide details: Card Issuing Company:

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CLAIM DETAILS	
Q15.	Date, Time & place the injury or illness occurred: Date: / / Time: : am/pm Place:
Q16.	The nature of the injury or illness and the FULL circumstances in which it arose (especially in the case of an injury). Please continue on a separate sheet if necessary.
Q17.	If injury, name and address of any witnesses:
Q18.	Where serious injury or death has occurred we will require copies of the relevant Authorities reports (Police / Fire department etc) we will obtain these. Please provide us with the name and address of the reporting Officer or Incident Reference number:
Q19.	Were the Assistance Company contacted **YES / NO** If 'YES' please provide name of company:
Q20.	Assistance Company Ref No (if known): What type of assistance did they provide?
Q21.	Was the travel representative involved **YES / NO** If 'YES' please provide a copy of any report obtained
Q22.	Were you admitted to hospital **YES / NO** If 'YES' please advise the name of hospital: and other details below;
Q23.	Date Admitted: / / Time: : am/pm Date Discharged: / / Time: : am/pm
Q24.	Total number of FULL 24 hour periods spent in hospital as an in patient: Do you feel all the treatment you received in hospital was necessary and reasonable **YES / NO**
Q25.	On what date did you return to your Country of Domicile / / Giving a total extended stay of days
Q26.	What items are you claiming for? **Please complete the following CLAIM EXPENSES SCHEDULE below**

Nature of Expense	Name of Supplier	Currency	Amount	*Please Tick if You Paid This*	*Please Tick if Unpaid & You Want Us To Settle Direct*
	TOTALS				

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RECIPROCAL HEATHCARE ARRANGEMENTS (EU FORM E111& SIMILAR) & OTHER INSURANCE & THIRD PARTY DETAILS	
Q27.	For travellers from the EU travelling within the EU: Did you obtain the form E111 or EHIC (European Health Insurance Card) from the DSS to entitle you to reduced medical costs in an EEC country and was this used? **YES / NO** If you obtained the form, and still have it in your possession, please forward it to us: Form obtained: **YES / NO** Form attached: **YES / NO** *(delete as applicable)* For travellers from outside the EU: Where you know, you are travelling to a country where your usual Country of Domicile has a Reciprocal Heathcare arrangement please ensure that you have completed the relevant forms to entitle you to reduced medical costs in the country you are visiting. You may need to obtain a certificate or id card from your relevant health authority to do this. If this is the case was the certificate / card used **YES/NO** If you still have either of these documents in your possession, please forward it to us: Form obtained: **YES / NO** Form attached: **YES / NO** *(delete as applicable)*
Q28.	Do you have any other private medical insurance i.e. BUPA, PPP or any other insurance that may cover these expenses? If so you may be able to reclaim your excess from this policy please provide details below: Company Name & Address: Membership Number: Policy Number:
Q29.	Has this claim been submitted (or will it be) to the Department of Social Security (or equivalent if not in the UK) or other insurer? **YES / NO** Their ref (if known):
Q30.	Was the injury or illness caused by another party? **YES / NO** If 'YES' please provide the name and address of the other party and full reasons why you or your advisors consider they were to blame. Name & Address: Reasons:
Q31.	Has a claim been made against the other party named in Q30? **YES / NO** If 'YES' please provide details and the name, address and reference of any company handling the matter on your behalf: Their reference number:

POLICY EXCESS - IMPORTANT!

The Policy Excess is the amount deductible from each and every claim.

If you require us to pay any bills direct, please confirm below whether the Policy Excess was paid and submit a receipt to show the payment.

If you did not pay the Policy Excess to the Doctor/Hospital at the time of treatment then please remit a cheque payable to ASUA Ltd* for the appropriate sum *(please refer to your Policy Conditions for details of the amount)*.

*ASUA Ltd are the Extramile Insurance Scheme Administrators and hold Premium on behalf of Almaseer Insurance Company and Lloyds Underwriters, they are FCA regulated and come under the Financial Services Compensation Scheme (FSCS)

Q.32 **Excess Paid? YES / NO** If 'YES' to whom (name of Doctor/Hospital):

Q.33 **Currency Used:**	Q.29 **Amount Paid:**

Q.34 **Are further accounts to be submitted? YES / NO** If 'YES' please provide details:

Q.35 **To whom do you wish any personal payment to be made if different to the Claimant named in Q01?**	**Name:**

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DECLARATIONS TO BE COMPLETED IN ALL CIRCUMSTANCES

PREVIOUS CLAIMS	
Q36.	Have you or any other person named on this form ever made any previous claim for medical or other expenses against this or any other Insurer: **YES / NO** *(Please continue on a separate sheet if necessary)*
1.	a) Date: / / b) Incident: c) Amount claimed d) amount settled e) i) Insurer who claim was with ii) Adjuster who dealt with claim
2.	a) Date: / / b) Incident: c) Amount claimed d) amount settled e) i) Insurer who claim was with ii) Adjuster who dealt with claim

DATA PROTECTION NOTICE

AICUK Ltd may use your information together with other information for underwriting, statistical analysis and claims. We may disclose your information to our service providers, agents and business partners for these purposes. We may also share your information with other interested parties and outside agencies to check the details and prevent fraudulent claims. We may also disclose your information to our agents to investigate or prevent fraud.

DECLARATION – To Be Completed By The Claimant Aged Over 16 or the Next of Kin if Aged Under 16

AICUK Ltd, agents and business partners may contact anyone who can give them information relevant to my claim. I confirm that the information that I have given is true and if any of the information given by me (or anyone on my behalf) is incorrect, I agree that such inaccuracy may cause me to forfeit my rights under the policy.

In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.

Payments: Subject to admission of liability, we will make payment in favour of the claimant **(aged over 16)** as detailed in question 01 overleaf but if an alternative payee is required please state below.

I have read and fully understood the above declaration.

Name	Signature	Date of Birth	Date of Signature
		/ /	/ /
Relationship to Claimant (if different)			

Please ensure you have completed this form in its entirety and have used the check list to ensure all the relevant documentation has been scanned and is sent by email with this form. Where we request that we need a hard copy of any information sent to us electronically we will only accept original documentation not copies or duplicates.