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 Institution (University, College etc):

Certificate No:

Date on which Travel commenced:

Full Name of Person Covered: Date of Birth:
Title (Mr, Mrs, Miss, Ms):

Full Address:

Postcode:

Tel No. (Business): (Home):

Email:

Full Name 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:-
a) where the accident occurred:_____
b) how the accident occurred: _____
c) 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 also provide us with a letter from the Person Covered's attending doctor confirming their fitness to travel at the time of booking the trip

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

DETAILS OF EXPENCE - ALL ACCOUNTS BILLS, RECEIPTS, MEDICAL CERTIFICATES, BOOKING INVOICES, ANY CORRESPONDENCE AND ANY OTHER DOCUMENTS RELATIVE TO THIS CLAIM SHOULD BE FORWARDED TO THE COMPANY

Claimant Name	Nature of Expense	Name and address of Doctor or Hospital attended	Currency Being Claimed	Amount £	Paid (√)

TOTAL £

PLEASE ENSURE YOU PROVIDE ORIGINAL RECEIPTS/INVOICES FOR ALL EXPENDITURE.

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.

As failure to do so will result in delay in handling you claim.
Please return the completed claim form together with any enclosures to

U M Association Ltd., Hasilwood House, 60 Bishopsgate, London EC2N 4AW

Thank you for fully completing this form.