ACE European Group
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Claim Form

MEDICAL EXPENSES

PLEASE USE BLOCK CAPITAL LETTERS USING BLACK INK AND ENSURE YOU SIGN THE DECLARATION ON THIS 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 POLICYHOLDER	CERTIFICATE/POLICY NO.
FULL NAME OF INSURED PERSON (MR/MRS/MISS/MS)	DATE OF BIRTH
FULL ADDRESS	
	POSTCODE
TELEPHONE NO. BUSINESS	TELEPHONE NO. HOME
FOR SECURITY PURPOSES PLEASE PROVIDE A PASSWORD WHICH WILL BE REQUIRED TO ACCESS YOUR CLAIM INFORMATION:	E-MAIL ADDRESS

FULL NAME OF CLAIMANTS	DATE OF BIRTH	RELATIONSHIP TO INSURED PERSON
1		
2		
3		
4		

ACCIDENT/SICKNESS DETAILS

DATE _____ PLACE _____

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

If YES please provide details: _____

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 your illness: _____

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

If YES please give details with relevant dates: _____

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

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 _____

DETAILS OF EXPENSE ALL ACCOUNTS, BILLS, RECEIPTS, MEDICAL CERTIFICATES, BOOKING INVOICES, ANY CORRESPONDANCE 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 £

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 **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
3. I authorise such Doctor to disclose such information to ACE.
4. I agree that a copy of this consent shall have the validity of the original.

SIGNED _____ DATE _____

PAYEE'S BANK DETAILS WHEN THE CLAIM HAS BEEN APPROVED YOU MAY HAVE THE PAYMENT CREDITED DIRECT TO YOUR BANK ACCOUNT. THIS PAYMENT METHOD IS BOTH SPEEDIER AND SAFER THAN BY CHEQUE. IF YOU WOULD LIKE TO TAKE ADVANTAGE OF THIS ARRANGEMENT THEN PLEASE COMPLETE THE FOLLOWING:-

Name of your Bank/Building Society: _____
Bank

Address _____

_____

_____

_____ Postcode _____

Bank Sort Code (from the top right hand corner of your cheque)

Account Number _____

Account Name(s) _____

IBAN: _____

BIC: _____

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 1988. 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.

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 YOUR INSURANCE BROKER OR TO ACE EUROPEAN GROUP LIMITED. 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 YOUR CLAIM

Thank you for fully completing this claim form.