



Course-u-can.com STUDENT STUDYGUARD

your student travel insurance **Claim Form**



**THANK YOU FOR NOTIFYING US OF YOUR CLAIM. PLEASE COMPLETE ALL QUESTIONS.
IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE 'N/A'.
PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS FORM**

Name of Policyholder (school/college in the UK/Eire) : Gibbs Denley Student Travel Scheme
Policy No. : **UKBSTC46859/**
(please insert the additional numbers as shown on your policy summary/certificate)

Full name of Insured Person (Mr, Mrs, Miss, Ms) :

Date of birth :

Full address :

Postcode:

Telephone No. (Business) :

Telephone No. (Home) :

E-mail address (this will be used to contact you regarding your claim) :

DETAILS OF EXPENSE - All accounts, bills, receipts, medical certificates, booking invoices, any correspondence and any other documents relative to this claim should be forwarded to ACE:

Insured Person	Nature of expense	Name and address of doctor or hospital attended	Currency being claimed	Amount	Paid

TOTAL : **£**

MEDICAL EXPENSES - accident/sickness details. Please provide a copy of your original itinerary/travel documents if available :

Date of trip :

Please give exact date and place when injured or taken ill : DATE :

PLACE :

If **accident**, please state fully :

(a) Where the accident took place :

(b) How the accident occurred :

MEDICAL EXPENSES - accident/sickness details *Continued*

(c) The injuries sustained :

If **illness**, please state full details of illness :

Have you (the Insured Person) ever suffered from this illness before? YES / NO

If YES, please give details with relevant dates :

PLEASE ALSO PROVIDE A LETTER FROM YOUR DOCTOR TO SAY THAT YOU (THE INSURED PERSON) WERE FIT TO TRAVEL.

Please state whether you (the Insured Person) were in hospital : YES / NO

If YES, please state dates of hospitalisation : Admitted : Discharged :

Have you (the Insured Person) previously claimed under this or a similar policy? YES / NO

If YES, please give details :

Are you (the Insured Person) 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 :

CANCELLATION / CURTAILMENT - Travel Details

Please give the reason for the Cancellation/Curtailment of the journey :

Please state the scheduled times of travel :

Outward date : Return date : Date Journey Booked :

Date of Cancellation/Curtailment : Please provide a copy of your flight details including any transfers, accommodation and course booking documents.

If the Cancellation/Curtailment was due to illness or injury, please state :

(a) The name and age of sick/injured person :

(b) The exact nature of illness/injury and the commencement date :

(c) Has the person concerned previously suffered the same or a similar complaint? YES / NO

If YES, please give details with relevant dates :

PLEASE PROVIDE MEDICAL EVIDENCE FROM THE ATTENDING DOCTOR OR PLEASE ASK THE ATTENDING DOCTOR TO COMPLETE THE FOLLOWING:-

Nature of complaint preventing travel :

Date of treatment first sought :

Was the cancellation of the journey medically necessary? YES / NO

Signed :

Date :

VALIDATION STAMP

If journey was **cancelled** please give details of expenditure incurred :

Total amount paid :

Total amount refunded :

Amount to be claimed :

PLEASE PROVIDE A CANCELLATION INVOICE TOGETHER WITH TRAVEL DOCUMENTS FROM THE TOUR OPERATOR, TRANSPORT CARRIER OR ACCOMMODATION AGENT.

If journey was **curtailed** please provide details of additional travel and sundry expenses including how these were incurred. **Receipts need to be enclosed for these charges.**

PERSONAL INJURY DETAILS

Please give exact date and time when injured : Date :

Time :

am / pm

Please state fully :

(a) Where the accident occurred :

(b) How the accident occurred :

(c) The injuries sustained :

Have you (the Insured Person) previously claimed under this or a similar policy? YES / NO

If YES, please give details :

Please give the name and address and policy number of any other insurance that **may** cover this injury :

PERSONAL BELONGINGS AND MONEY - Travel Details

Please give date of loss/damage/theft :

In which country did the loss/damage/theft occur?

Please give full details of the loss/damage/theft :

To whom was the loss/damage/theft reported? Please provide a copy of this report

NOTES :

1. All losses should be reported to the local police and a report obtained. This should be forwarded to ACE.
2. All losses or damaged property which occurred whilst in the custody of an airline should be reported and a Property Irregularity Report Form obtained. This should be forwarded to ACE together with the ticket stubs.

On which date was the loss/damage/theft reported?

If article(s) **lost/stolen** :

What steps were taken regarding recovery of the article(s)? Please provide any written evidence.

If article(s) **damaged** :

Please supply estimates for cost of repairs or a letter from an appropriate dealer confirming irreparably damaged.

Please supply receipts - if not available please supply replacement estimates/invoices.

Is any property lost/damaged/stolen insured by any other company? YES / NO

If YES, please supply name, address, telephone number and policy number :

Please supply name, address, telephone number and policy number of household contents insurers :

Have you had any previous claims on this type of insurance? YES / NO

If YES, please give details with relevant dates :

Please ensure the 'Particulars of Claim' section overleaf is fully completed.

DOCTOR'S STATEMENT - This section must be fully completed by attending doctor.
You (the Insured Person) are responsible for any fee to complete this section.

Patient's name (Mr, Mrs, Miss, Ms) :

Date of birth :

Height :

Weight :

Please give full details of injury :

Final diagnosis :

When did the patient first receive medical attention for this condition?

Has the patient ever suffered with this or any similar condition before the present episode? YES / NO

If YES, please give details including dates, treatment and consultation :

Are you the patient's usual doctor? YES / NO

If NO, please give name and address of usual doctor :

On what date did incapacity commence?

Is the patient still incapacitated? YES / NO

If YES, when will the patient be able to return to their studies?

If NO, when did incapacity cease?

Was the patient hospitalised as a result of this condition? YES / NO

Is there any additional information that you feel is relevant?

Signed :

Date :

Qualifications :

Please use Validation Stamp or complete in BLOCK CAPITALS:

Name :

Address :

Postcode :

Telephone No.

VALIDATION STAMP

Thank you for your assistance in completing this form.

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 also 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/she 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 (the Insured Person) 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 :** _____
(Please sign this if you are aged 18 years or more. If you are aged under 18 years this must be signed by your parent/legal guardian or an authorised person at your school/college, on your behalf.)

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, please complete the following :

Name and address of your bank/building society:

Address

Currency required, if other than **£ Sterling**

Account Name

Account Number

Branch Sort Code

Postcode

IBAN Number

If payment has already been made on your behalf, please give details to whom this claim payment should be made :

Name :

Address :

Postcode :

DATA PROTECTION

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.

ACE shall mean ACE European Group Limited, registered in England Number 1112892, Head Office: 100 Leadenhall Street, London, EC3A 3BP, which is authorised and regulated by the Financial Services Authority (FSA), registration number FRN202803. Full details can be found on the FSA's Register by visiting <http://www.fsa.gov.uk/register> or by contacting the FSA on 0845 606 1234

DECLARATION - I declare that all the information given is to the best of my knowledge and belief, full true and correct.

Signed : _____ **Date:** _____
(Please sign this if you are aged 18 years or more. If you are aged under 18 years this must be signed by your parent/legal guardian or an authorised person at your school/college, on your behalf.)

CHECKLIST - Please ensure you have:

- completed **ALL** relevant questions on this claim form
- enclosed all requested information and documentation
- signed this claim form

AS FAILURE TO DO SO WILL RESULT IN A DELAY IN HANDLING YOUR CLAIM.

Please return the completed claim form together with any enclosures to :
ACE European Group Limited, Claims Service Team, 200 Broomielaw,
Glasgow, G1 4RU

tel: 0845 841 0056 (within UK only)

international: +44 (0)141 285 2999

fax: +44 (0)1293 597 376

e-mail: claims@acegroup.com

