CLAIM FORM

Personal Accident / Sickness

ACE European Group
ACE Travel Insurance Claims
OSG, Merrion Hall, Strand Road,
Sandymount, Dublin 4
tel: 1800 719 420 or
+353 (0)1 440 1757

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 no.			
MAIN POLICYHOLDER DETAILS			
Title	First name	Last name	
Email address		Date of birth (DD/MM/YYYY)	
Full address			
		Postcode	
Contact no. Daytime		Contact no. Evening	
For security purposes please provide a password which will be required to access your claim information *This is for additional security and you may be asked for it when calling ACE.*			

INSURED PERSONS DETAILS			
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			

insured.™

EMPLOYMENT DETAILS

What is your occupation? _____

Please describe your duties _____

_____

Name & Address of Employer: _____

_____

_____

Email address of Employer _____

Please state average annual gross and net salary over previous 12 months from the date of the incident *(please enclose copies of 13 weeks payslips prior to the event)* or over the previous 36 months from the date of accident if self employed *(please provide evidence of income by means of Inland Revenue Tax Assessment forms or audited accounts)*:

GROSS _____ NET _____

ACCIDENT/SICKNESS DETAILS

Please give exact date and time when injured or taken ill: DATE _____ TIME _____ am / pm

Please state:-

(a) The date you ceased working: _____

(b) The date you returned to work: _____

(c) If you have not returned to work, on which date do you hope to do so? _____

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 ever suffered from this illness before? YES / NO

If YES please give details _____

_____

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

If YES please give details _____

_____

_____

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

_____

_____

HOSPITAL STATEMENT only to be completed if claiming hospitalisation benefit

This section must be fully completed by hospital medical staff or records – any fee for completion of this section is the responsibility of the beneficiary of insurance

(a) Type of hospital/ward: _____

(b) Name of Doctor or Consultant in charge: _____

(c) The dates admitted and released: ADMITTED: _____ RELEASED: _____

(d) Was any period spent in intensive care: YES / NO FROM: _____ TO: _____

(e) Was the patient subsequently confined to their home on medical grounds? YES / NO

If YES, please give dates: FROM: _____ TO: _____

Is there any additional information that you feel is relevant? _____

_____ _____

SIGNED DATE

Position held in Hospital: _____ Qualifications: _____

Please use validation stamp or complete in block capitals:-

VALIDATION STAMP

Hospital Name: _____

Address: _____

_____

Telephone No: _____

Thank you for your assistance in completing this form.

DOCTOR'S STATEMENT

This section must be fully completed by attending doctor – any fee for completion of this section is the responsibility of the beneficiary of insurance

Patient's Name: (Mr, Mrs, Miss, Ms) _____

Date of Birth: _____ Height: _____ Weight: _____

Please give full details of injury/illness: _____

_____

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 patient still incapacitated? YES / NO

If YES when will patient be able to return to work? _____

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:-

VALIDATION STAMP

Name: _____

Address: _____

_____

Telephone No: _____

Thank you for your assistance in completing this form.

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 _____

_____

Address _____

_____

_____

_____

IBAN _____

BIC _____

Account Number _____

Name of Account Holder(s) _____

_____

_____

DATA PROTECTION

Any information that you or your medical representative provides in the claim form and/or Doctor's Statement is "sensitive data" as defined by the Data Protection Acts of 1988 and 2003. 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 in 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 and private investigators 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 Ireland, 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. Guidelines for sharing of information in this regard are contained in a Code of Practice on Data Protection for the Insurance Sector which has been approved by the Data Protection Commissioner.

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.
- I give permission for any Medical Practitioner, Law Enforcement Agency or Statutory/Regulatory Authority mentioned with respect to this claim, to release information regarding my records.

_____ _____

SIGNED DATE

CHECKLIST

Please return the completed claim form together with any enclosures to your insurance broker or to ACE European Group Limited and please ensure...

- ☐ You fully complete every question **before** your doctor completes his statement
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ You have signed this claim form
- ☐ Your attending doctor fully completes the statement

If you do not complete all sections and provide all requested documentation your claim will be delayed.