

CLAIM FORM

Medical Expenses

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 <i>This is for additional security and you may be asked for it when calling ACE.</i>			
INSURED PERSONS DETAILS			
Full name	Date of birth (DD/MM/YYYY)	Relationship to main policyholder	I intend to claim on behalf of: (<input checked="" type="checkbox"/>) where applicable
MAIN POLICYHOLDER AS ABOVE			



insured.™

ACCIDENT/SICKNESS DETAILS please provide a copy of your original itinerary/travel documents if available

Type or travel: Business / Holiday _____ Date of Trip _____

Please give exact date and place where injured or taken ill: 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 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 QUINN/VHI 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 Republic of Ireland _____

Please also provide us with a letter from your/the claimants attending doctor confirming it was in order for you to travel.

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 _____ IBAN _____
_____ BIC _____
Address _____ 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 have completed **all** relevant questions on this claim form
- You have enclosed all requested original documents (we recommend you retain copies)
- You have signed this claim form

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



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