Alliance Africa General Insurance Limited
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Covering Risk. Improving Lives.

TRAVEL INSURANCE – MEDICAL EXPENSES CLAIM FORM

(Please complete this form and return it with all relevant documentation to the above address. Filling this form is not an admission of liability.)

1. Claim Reference

- **Claim Reference:** .....

2. Personal Details

- **Name:** .....
- **Date of Birth:** .....
- **Occupation:** .....
- **Telephone:** .....
- **Hours of Contact (at above number):** .....

3. Insurance Details

- **Policy Name:** .....
- **Date Trip Originally Booked:** .....
- **Travel Dates:** From ___ / ___ / ___ To ___ / ___ / ___
- **Name of Travel Agent (if any):** .....
- **Name of Tour Operator (if any):** .....
- **Hotel Accommodation Details:** .....
- **Resort/Country:** .....
- **Do you have Private Medical Insurance?** Yes / No
    - If Yes, give details: .....

4. Medical & Emergency Expenses / Hospital Benefit

- **Date of Injury/Illness Onset:** .....
- **Details of Injury/Illness:** .....

- **Circumstances of Accident (if applicable):** .....
- **Previous Similar Condition?** Yes / No
    - If Yes, usual doctor to complete attached medical certificate.
- **Hospitalisation Dates:**
    - Admitted: ___ / ___ / ___
    - Discharged: ___ / ___ / ___
- **Valid E111 Form (EC travellers only)?** Yes / No
    - If No, provide National Insurance Number: .....
- **Signature (to authorise SAS to use E111):** .....

5. Treatment & Expenses

Date of Treatment	Nature of Expenses Claimed	Amount Claimed

- **Total Amount Claimed:** .....
- **Settlement To Be Paid To:** .....

6. Required Documents

Please enclose the following originals:

1. Holiday/flight confirmation or deposit receipt – Yes / No
2. Certificate of Insurance – Yes / No
3. Travel tickets – Yes / No
4. Hospital/Doctor/Chemist/Dentist receipts (Non-UK only) – Yes / No
5. Receipts for additional travel/accommodation expenses – Yes / No
6. Confirmation of in-patient treatment (for hospital benefit claim) – Yes / No

7. Any other relevant documentation – Yes / No

8. **Declaration and Data Collection Consent**

Data Collection Consent: I consent to the collection, verification, processing, storage and lawful use of my personal data for identification, regulatory compliance, and the provision of insurance services

I declare that to the best of my knowledge all particulars contained in this form are true and correct.

- **Signed:** .....
- **Date:** .....

Medical Certificate

(To be completed by the usual doctor of the claimant. Any charges are the responsibility of the insured person.)

- **Claim Reference:** .....
- **Claimant's Name:** .....
- **Date of Birth:** .....
- **Patient's Name (if different):** .....
- **Patient's Date of Birth:** .....
- **Relationship to Claimant:** .....

Patient's Consent for Release of Medical Information
I authorise the medical practitioner named below to release any information required by Insurers or their appointed agents to enable my claim to be processed.

- **Signed:** .....
- **Date:** .....

Doctor's Section

- How long have you been the patient's usual doctor? .....
- Precise nature of medical condition/illness/injury/cause of death: .....
- Date first consulted for this problem: .....

- Was patient waitlisted for hospital admission? Dates: .....
- Relevant previous medical history (last 30 months): .....
- Was patient fit to travel as proposed? Yes / No
- Terminal prognosis given? Yes / No
- Is patient pregnant? Yes / No
    - If Yes, E.D.D.: .....

Certification

I, Dr. ..... confirm that the above information is correct.

- **Signed:** .....
- **Qualifications:** .....
- **Date:** .....
- **Address:** .....
- **Official Stamp:** .....