InsureandGo Ireland Claims
Ireland Assist House
22-26 Prospect Hill
Galway

Dear Sir/Madam

Travel Insurance Claim

Please find enclosed a claim form for completion and return to the address shown above.

You should complete all sections relevant to your claim and enclose all requested supporting documentation (**which must include evidence of your outward and return travel dates from the Republic of Ireland**). Please note an incomplete application may delay the processing of the claim.

You must as part of the policy terms and conditions declare if you have any other travel, household or other insurances in force at the time of your claim (this includes any insurance which may have been provided in association with your bank account). **Withholding this information may delay the processing of your claim.**

If additional information or documentation is required we will reply using the e-mail address supplied when you purchased the policy. Please ensure that you provide your current e-mail address on the enclosed claim form before returning it to us.

If you have any **queries or you require assistance** in completing the claim form please do not hesitate in contacting us on 091 545 907. Please have your claims reference number to hand.

Yours sincerely,

For and on behalf of
InsureandGo Ireland Claims

InsureandGo Ireland Claims
22-26 Prospect Hill
Galway, Ireland
claims@insureandgo.ie

TRAVEL INSURANCE CLAIM FORM

	Claim Reference Number:
	Policy Number:

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS

CLAIMANT DETAILS

NAME OF LEAD CLAIMANT: Title: ____ Forename: _____ Surname: _____

Sex: M/F D.O.B. _____ Occupation: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE NO: Home _____ Work _____ Mobile_____

LEAD POLICYHOLDER NAME: Title: ____ Forename: _____ Surname: _____

Claimant's Relationship to Lead Policyholder: _____

HOLIDAY/TRIP DETAILS

Tour Operator: _____ Travel Agent: _____

Destination/Country: _____

Date holiday booked: _____

Departure Date: _____ Return Date: _____

PREVIOUS CLAIM DETAILS:

Have you made an insurance claim in the past 5 years? **YES/NO**

If YES please provide details:

Date	Type Of Claim	Amount Claimed	Company

DECLARATION: Insurers and their agents share information to prevent fraud and for underwriting purposes. This document, information provided when taking out the Policy and relevant facts form the basis of your claim and may be shared or used for audit purposes. It is a criminal offence to make a fraudulent claim. We investigate all cases and any person suspected of fraud is reported to the Police/Gardai with whom we always cooperate in effecting a prosecution. I/We understand that you may seek information from other insurers to check that the information provided above is truthful and that details of this claim can be used for audit purposes. I/We understand that you may request information from medical providers abroad in relation to a claim where medical advice was sought. I/We declare that to the best of my/our knowledge and belief that all the information I/We have given is correct. I/We have not withheld any information connected with this incident and agree to provide any further information or documentation as may be required. I understand that the insurer does not admit liability by the issue of this form.

ALL PERSONS CLAIMING MUST SIGN BELOW:

Name (please print)	Signature	Date

MEDICAL EXPENSES - CLAIM DETAILS

Is this claim for: Medical Treatment: _____ Dental Treatment: _____

Date of injury/onset of illness: _____ Description of injury/illness:_____
Did you make a medical declaration prior to Booking your Trip/Purchasing your Insurance: YES/NO
If 'Yes', please provide reference number: _____

Please provide details of your usual treating GP:
Name: _____ Address: _____
Do we have your authority to contact him/her? _____ If YES, please sign: _____

Were you hospitalised abroad as a result of your injury/illness? _____
If YES: Admission Date: _____ Discharge Date: _____

Did you contact our 24-hour emergency service? _____ Date: _____ Advisor you spoke to: _____
If NO please state the reason: _____
Have you received payment from any other source? _____
If YES, please provide details: _____

OTHER INSURANCE:

Do you have Private Medical Insurance? _____
If YES, please provide details: Company Name:_____ Policy Number: _____Plan:____
Do you have an E111 / European Health Insurance Card? _____ If YES, please attach copy.

EXPENDITURE DETAILS:

Date Expense Incurred	Description	Foreign Currency Amount	Rate of Exchange	Bill Paid - Yes/No	Office Use Only

Payment Details **(Please tick the appropriate form of payment):**

Cheque:_____ Bank Transfer:_____
If you wish to receive payment by bank transfer, please supply us with the following information;
(NB Payment cannot be issued by bank transfer unless all below details are provided)
Bank Name and Branch:_____
Account Holder's Name:_____ Account Number:_____
Sort code:_____ IBAN Number:_____ BIC/Swift code: _____

CHECKLIST: **Please ensure you sign the declaration overleaf and enclose the following ORIGINAL documents as applicable:**

All Claims:

Booking Invoice/Travel Tickets showing travel dates and flight/accommodation cost YES/NO
Certificate of Insurance (photocopy only) YES/NO
Hospital / Doctor / Pharmacist receipts/invoices for amounts claimed YES/NO
Report from your treating doctor abroad confirming condition for which treatment was sought YES/NO
Receipts for any additional expenses incurred (admissible under the policy) YES/NO
Copy of E111 / European Health Insurance Card YES/NO

Medical Inconvenience/Benefit Claims:

Letter from treating doctor abroad confirming hospitalisation dates (unless MAPFRE involved) YES/NO

MEDICAL CERTIFICATE -

To be completed by the USUAL TREATING GENERAL PRACTITIONER of the person whose illness/injury/death gives rise to the claim. Any charges incurred for the completion of this certificate are NOT refundable under the terms of the insurance policy

Name of person to whom this certificate applies: D.O.B. _____

Are you his/her usual treating GP? _____ If YES, for how long? _____

At the latter of either the time the policy was issued, or the holiday was booked (please ask the claimant), were you aware of any medical condition which could give rise to a claim: _____

If YES, please outline details: _____

_____

Please describe the CONDITION which gives rise to this claim:

When did the patient first consult for this condition? _____

Has the patient been referred to a Consultant/Specialist/Hospitalised in the last 3 years?_____

If YES, please outline details including dates and condition for which he/she was referred: _____

_____

_____

Please provide details of consultations in the 3 years prior to the inception of the insurance policy:

(NB - **Please complete this section in full as it may result in the document being returned if all details are not provided)**

Date of Consultation	Reason for Consultation	Medication Prescribed

Was the patient on a waiting list/awaiting results for any tests/treatments or consultation(s) at the time of inception of the insurance?_____ If YES, please provide details: _____

Had the patient received a terminal prognosis at the time of inception of the insurance?_____

If claim is related to Pregnancy:

Date Pregnancy confirmed: _____ Estimated Due Date: _____

Medical condition associated with pregnancy, which necessitates cancellation:

_____

Doctor's Declaration:

I certify that the reason for this claim was due only to the medical reasons stated above and, in the case of a claim for cancellation, that cancellation was medically necessary.

Doctor's Name (please print) _____ Doctor's Official Stamp:

Signature: _____

Qualifications: _____

Date: _____