Chubb European Group SE
Travel Insurance Claims
OSG, Merrion Hall,
Strand Road,
Sandymount, Dublin 4

T: 1800 719 420 or
+353 (0)1 4401757

Claim form
Medical expenses

Data protection

We use personal information which you supply to us [or, where applicable, to your insurance broker] for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: https://www2.chubb.com/ie-en/footer/privacy-policy.aspx or by searching 'Master Privacy Policy' on https://www2.chubb.com/ie-en/. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

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 number

Main Policyholder details

Title	First name	Last name

Email address	Date of Birth (DD/MM/YY)

Full address

	Postcode

Contact no. (day)	Contact no. (eve)

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 Chubb.

Insured persons details

Full name	Date of Birth (DD/MM/YY)	Relationship to main policy holder	I intend to claim on behalf of: (✓) where applicable

Accident/Sickness details (Please provide a copy of your original itinerary/travel documents if available)

Type of travel: Business: ☐ Holiday: ☐ Date of trip: _____

Please give exact date and time when 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 relavant days

Please state whether you/the claimant were in hospital Yes: ☐ No: ☐

If yes please sate 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 _____

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.

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 the company

Claimant name	Nature of expense	Name & Address of Doctor or Hospital attended	Currency being claimed	Amount €	Paid: (✓)
			Total €		

Explicit Consent to use Health Information- Important Please Read

We carefully assess your claim, and also take steps, in common with standard industry practice, to monitor for fraudulent claims. For these reasons, we may need to use information about your health which is relevant to your claim, and, where relevant, the health of other persons relevant to the claim which you provide to us. ***You must ensure that any other persons whose information you provide to us understand and do not object to this use of their data, and (where required under applicable law) consent to us using their information for the purposes described here.***

We will not use this health information for any other purpose, and will comply at all times with the terms (including security standards) referred in our Privacy Policy. You do not have to provide us with the following consent, and you may withdraw it at any time, but if you do not provide it, or choose to later withdraw it, that may affect our ability to process your claim.

Please tick the following box to indicate your consent to our use of your health information in this way. ☐

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: _____

_____

_____

_____

_____ Postcode: _____

Bank sort code

IBAN: _____

BIC: _____

Account number: _____

Name of account holder (s): _____

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: _____

Name: **Date:**

Checklist

Please ensure:

- ☐ You have completed **all** questions on this claim form included any marked 'N/A'
- ☐ You have enclosed all requested information /documentation
- ☐ You have signed the declaration section

Failure to do so will result in a delay in handling your claim

Chubb. Insured.℠