CHUBB

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

T: 1 800 242 467 or
+353 (0)1 440 1766

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.
Once completed please email to travel@ie.sedgwick.com and include any supporting documentation.

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)

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 relevant 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 i.e. QUINN/VHI or any similar 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.

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: (✓)
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			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.℠

Chubb European Group SE trading as Chubb, Chubb Bermuda International and Combined Insurance, is authorised by the Autorité de contrôle prudentiel et de résolution (ACPR) in France and is regulated by the Central Bank of Ireland for conduct of business rules.

Registered in Ireland No. 904967 at 5 George's Dock, Dublin 1.

Chubb European Group SE is an undertaking governed by the provisions of the French insurance code with registration number 450 327 374 RCS Nanterre and the following registered office: La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, France. Chubb European Group SE has fully paid share capital of €896,176,662.