RECOVERY FORM - MEDICAL

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It is a condition of your insurance that you provide us with details of any other person or company which may be able to contribute towards the cost of your claim. This enables the insurers to keep insurance premiums down by ensuring that all liable parties contribute towards the loss. On some occasions, it also enables us to claim additional amounts on your behalf.

Please complete each of the following sections, as appropriate, and return to us.

Recovery Information (do not leave any question blank as this will delay your claim)

Part 1: Credit Card Details

Do you have a Credit Card? YES / NO How much of the trip was paid by Credit Card? NONE / PART / ALL

Name of Credit Card Company:

Type of credit card: e.g. gold, platinum etc.:

IMPORTANT: DO NOT ENTER VISA / MASTERCARD AS THESE ARE THE PAYMENT PROCESSORS

Part 2: Current Account Details

A number of bank accounts now offer free, annual travel insurance as one of the benefits. Many people are unaware of this, so we ask all customers to confirm which company they hold their current account with:

Name of Bank:

Level and name of Account: e.g. Gold Premier, Royalties Gold etc.:

Name of Account Holder if different from claimant (e.g. Parent):

IMPORTANT: DO NOT ENTER 'CURRENT ACCOUNT' WE NEED TO KNOW THE LEVEL OF ACCOUNT.

Part 3: Dual Travel Insurance

Do you have another travel insurance policy in place? YES / NO

Company Insurance was bought from:

Name of policy (if known):

Policy number (if known):

Part 4: Private Medical Insurance

Is there private medical insurance covering any of the claimants: YES / NO

If YES, please provide the Insurer name and address:

Policy/ reference number:

Part 5: EHIC (UK Residents only)

ONLY COMPLETE THIS SECTION IF MEDICAL TREATMENT WAS REQUIRED IN EUROPE.

Do you have an EHIC card: YES / NO If YES, was it presented to the treating doctor/hospital: YES / NO

Please also confirm your National Insurance Number:

Part 6: Feuille De Soins (Expenses in France only)

If you incurred expenses in France and are submitting Feuille De Soins receipts, please sign them and send in the original.

Section 7: Third Party Liability

In your opinion, was anyone else responsible for the injury/illness giving rise to your medical costs? If YES, please confirm their details:

Name:

Contact details:

Please explain the circumstances and why you feel they are responsible:

Declaration

I declare that, to the best of my knowledge and belief, all information stated herein is correct and that the insurance company is subrogated with all rights I may have against any third party(s).

I have not withheld any information from insurers within my knowledge connected with my claim.

I agree to provide further information or documentation that may be reasonably required.

Signed:

Print name:

Date: / /