

**Medical Expenses Claim Form**

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Email- [avivatravelclaims@cegagroup.com](mailto:avivatravelclaims@cegagroup.com)

PLEASE USE BLOCK CAPITAL LETTERS USING BLACK INK

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| Name of Policyholder: UNIVERSITY OF LEEDS | | Policy No: 100003814GPA | |
| Full Name of Claimant: | | | |
| Address: | | | |
| Email address: | | | |
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| **Accident/Sickness Details** | | | |
| Date of Trip: | Planned Return Date: | | Date of Accident or Illness: |
| Place where injured or taken ill: | | | |
| If **Accident** please state fully:-  Where the accident occurred  How the accident occurred  The injuries sustained  If **Illness** please state full details of your illness and attach the medical report:  Have you ever suffered from this illness before? YES/NO  If YES, please state when you last suffered from this illness and confirm that you were not travelling against medical advice:  If the claim relates to dental treatment, please provide evidence that treatment was to relieve pain and was necessary  Were you hospitalised: YES/NO If YES, please give details of the hospital and date admitted and discharged  Please give name and address of your GP in the UK  Do you have any other medical insurance cover? If Yes, please provide details below: | | | |
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**DETAILS OF EXPENSES –** All accounts, bills, receipts, certificates, documents relative to this claim should be attached to this claim form, including the medical report

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| Claimant  Name | Nature of  Expense | Name of Doctor/Hospital | Currency being Claimed | Amount  Claimed | Paid  🗹 |
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| Total Claimed: |

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| **PAYEE’S BANK DETAILS** – When the claim has been approved, the settlement payment will be credited to your bank account. This payment method is both speedier and safer than by cheque. **PLEASE COMPLETE THE FOLLOWING** |
| Name of your Bank/Building Society \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Post Code \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   |  |  |  | | --- | --- | --- | |  |  |  |     Bank Sort Code  Account Number: Account Name \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
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| **Disclaimer** - To be signed by the person giving rise to the medical expenses claim  Country of Incident:    Date of Incident:  National Insurance  Number:  Your Nationality:    Date:  Signature:  Full name of the person who completed this form:      Date of Birth: |
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Please email this claim form to [avivatravelclaims@cegagroup.com](mailto:avivatravelclaims@cegagroup.com) **together with your planned travel itinerary, all relevant medical reports, and receipts.**