

**Medical Expenses Claim Form**

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Email- 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 occurredHow the accident occurredThe injuries sustainedIf **Illness** please state full details of your illness and attach the medical report:Have you ever suffered from this illness before? YES/NOIf 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 necessaryWere you hospitalised: YES/NO If YES, please give details of the hospital and date admitted and dischargedPlease give name and address of your GP in the UKDo 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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|  ClaimantName | Nature ofExpense | Name of Doctor/Hospital | Currency being Claimed | AmountClaimed | 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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 Bank Sort CodeAccount 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 InsuranceNumber: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 **together with your planned travel itinerary, all relevant medical reports, and receipts.**