Mapfre Assistance Agency Ireland Claims
Ireland Assist House,
22-26 Prospect Hill,
Galway, Ireland
traveldept@mapfre.com

MEDICAL & ASSOCIATED EXPENSES CLAIM FORM

	Claim Reference Number:
	Policy Number:

Thank you for your recent claim notification. Please ensure you read the below instructions carefully for returning the claim form and supporting documentation.

Claim form and supporting documentation:

1. Please complete all sections relevant to your claim, sign and date the form. **Please note an incomplete application will delay the processing of the claim.**

2. You must return this form to the postal address listed above and attach the following **ORIGINAL** documentation:

   ☐Booking Invoice/Travel Tickets showing travel dates and flight/accommodation cost
   ☐Hospital / Doctor / Pharmacist receipts & invoices for amounts claimed
   ☐Report from your treating doctor abroad confirming condition for which treatment was sought
   ☐Medical Certificate completed in full by the usual treating GP of the person whose condition gives rise to the claim
   ☐Receipts for any additional expenses incurred (admissible under the policy)
   ☐Copy of E111 / European Health Insurance Card
   Medical Inconvenience/Benefit Claims:
   ☐Letter from treating doctor abroad confirming hospitalisation dates (unless MAPFRE involved)
   Medical with Curtailment:
   ☐Booking invoice confirming emergency travel (to include passenger names, new travel date & cost)
   Medical with extended stay
   ☐ Booking invoices for the additional accommodation & travel costs to return home

   As the circumstance of each claim differs, on receipt of your claim form, it may be necessary for us to request additional information not outlined in the checklist above. **Failure to provide the above documentation may delay the processing of your claim.**

3. You must as part of the policy terms and conditions declare if you have any other insurance in force at the time of your claim (this includes any insurance which may have been provided in association with your bank account).

If you have any queries or require assistance in completing the claim form please do not hesitate to contact us. Please have your claim reference number to hand.

Yours sincerely,

For and on behalf of
Mapfre Assistance Agency Ireland Claims

MAPFRE ASISTENCIA Compania Internacional De Seguros Y Reaseguros, S.A., trading as MAPFRE ASSISTANCE Agency Ireland, is authorised by Direccion General de Seguros y Fondos de Pensiones del Ministerio de Economia y Hacienda in Spain and is regulated by the Central Bank of Ireland for conduct of business rules.

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MEDICAL & ASSOCIATED EXPENSES CLAIM FORM

Claim Reference Number:	(Please see first page of claim form for your reference)
Policy Number:	(Please see first page of claim form for your policy number)

Please complete all sections in **BLOCK CAPITALS**

SECTION A

CLAIMANT DETAILS

Title:		Gender:	
Forename:		Surname:	
Date of Birth:		Occupation:	
Address:		Home Phone Number:	
		Work Phone Number:	
		Mobile Number:	
		Email Address:	

TRIP DETAILS

Tour operator:		Booking agent:	
Destination:		Date trip booked:	
Departure date:		Return date:	

SECTION B

ANY OTHER INSURANCE DETAILS:

Travel Insurance policy? YES ☐NO☐
Insurance with your bank account / bank card? YES ☐ NO☐
Any other insurance policy which may cover this loss? YES ☐ NO☐
If Yes to any of the above, please provide Company Name & Policy Number: _____

PREVIOUS CLAIMS HISTORY:

Have you made ANY insurance claim in the past 3 years? (If yes, please provide details below) YES/NO

Year	Type Of Claim	Amount Claimed	Company

DECLARATION: Insurers and their agents share information to prevent fraud and for underwriting purposes. This document, information provided when taking out the Policy and relevant facts form the basis of your claim and may be shared or used for audit purposes. It is a criminal offence to make a fraudulent claim. We investigate all cases and any person suspected of fraud is reported to the Police/Gardai with whom we always cooperate in effecting a prosecution. I/We understand that you may seek information from other insurers to check that the information provided above is truthful and that details of this claim can be used for audit purposes. I/We understand that you may request information from medical providers abroad in relation to a claim where medical advice was sought. I/We declare that to the best of my/our knowledge and belief that all the information I/We have given is correct. I/We have not withheld any information connected with this incident and agree to provide any further information or documentation as may be required. I understand that the insurer does not admit liability by the issue of this form.

ALL PERSONS CLAIMING MUST SIGN BELOW:

Name (please print)	Signature	Date

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SECTION C

INCIDENT DETAILS

Please detail the medical condition / injury giving rise to your claim (If injury, please outline in detail how the injury was sustained):

_____

_____

Date symptoms first began / injury occurred: _____

Were you hospitalised abroad as a result of your injury/illness? _____
If YES: Admission Date: _____ Discharge Date: _____

Did you make a medical declaration prior to booking your Trip/purchasing your Insurance: YES/NO
If 'YES', please provide the medical screening reference number: _____

Did you contact our 24-hour emergency service? _____ Date: _____ Advisor you spoke to: _____
If NO please state the reason: _____

We may need to contact the Medical Practitioner if any point needs clarification. In order for us to do so, please give us your authority by signing below:

Signed:_____

Medical Practitioner's contact details:_____

EXPENDITURE DETAILS:

Date Expense Incurred	Description	Amount Paid	Refund Amount	Claimed Amount	Office Use Only

SECTION D

(NB Payment cannot be issued unless all below details are provided)

Bank Name and Branch:_____

Account Holder's Name:_____ Account Number:_____

Sort code:_____ IBAN Number:_____

DATA PROTECTION

The information you provide about yourself and third parties will remain confidential and may be used for the provision and administration of insurance products and related services. Such information may be disclosed in confidence for these purposes to agents or services providers appointed by MAPFRE ASSISTANCE Agency Ireland, regulatory bodies, other insurance companies (directly or via central register) and other MAPFRE Group companies inside and outside the European Economic Area, in confidence. This information will be processed and held on our computers and manual records subject to the provisions of the Data Protection Acts 1988 and 2003 and by providing us with your information and proceeding with this contract, you consent to all of your information being used, processed, disclosed, transferred and retained for the purposes of insurance administration (including underwriting, processing, claims handling and fraud prevention).

You have a right to request, a copy of the personal data MAPFRE ASSISTANCE Agency Ireland holds about you by sending a request in writing to the Data Protection Officer, MAPFRE ASSISTANCE Agency Ireland, Ireland Assist House 22-26 Prospect Hill, Galway, together with the payment of the applicable fee (currently €6.35). There is also a right to correct any inaccuracies in the personal data we hold about you.

MEDICAL CERTIFICATE

To be completed by the USUAL MEDICAL PRACTITIONER of the person whose illness/injury/death gives rise to the claim. Any charges incurred for the completion of this certificate are NOT refundable under the terms of the insurance policy. This information will be treated as private and confidential.

Notice to claimant: Please complete section 1, 2 & 3 prior to giving to the Medical Practitioner for completion

1. Date trip booked:	2. Date insurance purchased:	3. Travel dates:

Notice to Medical Practitioner: Please complete all sections as it may result in the document being returned if all details are not provided

Name of person to whom this certificate applies:	D.O.B
Are you his/her usual treating GP?	If YES, for how long?
Please describe the MEDICAL CONDITION / INJURY which gives rise to this claim:	
What date did the patient first consult for this condition (please specify the exact date)?	
How long were the symptoms in existence prior to consulting on the above date?	
Has the patient been referred to a Consultant/Specialist/Hospitalised in the last 2 years? If YES, outline details including dates and condition for which he/she was referred:	
Was the patient on a waiting list/awaiting results for any tests/treatments or consultation(s) at the time of inception of the insurance / booking trip? (Please refer to the top of this certificate for the dates) If YES, please provide details (including condition & dates of referrals:	
Has the patient received a terminal prognosis?	If YES, what date was this given?

Please provide details of all consultations in the previous 2 years:

Date of Consultation	Reason for Consultation	Medication Prescribed

Declaration

I certify that the above information is correct to the best of my knowledge.

Doctor's Name (please print) _____ Doctor's Official Stamp:

Signature: _____

Date: _____

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