

# Travel Claim form

Please complete clearly in **BLOCK CAPITALS**.

Are you submitting this claim as a scanned copy?  Yes  No

One form must be completed for each claimant.

Further information about how to complete this form can be found on the reverse.

**Your claim will be processed by Aetna Global Benefits (UK) Limited on behalf of the insurer. Failure to complete all sections marked 'must be completed' on this form may result in delays.**

## Section A: Claimant details - must be completed

Title: <input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms				Other:			
Family name (surname):				First name(s):			
Date of birth (dd/mm/yyyy):				Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female			
Member number:				Plan number:			
Correspondence address:							
Town:			Postcode:			Country:	
Email:							
Daytime phone:				Evening phone:			

## Section B: Main member details (if different from section A)

Family name (surname):				First name(s):			
Member number:				Plan number:			

## Section C: Medical expenses and repatriation – must be completed by the medical practitioner/specialist/therapist

Nature of illness or injury or cause of death:							
If injury, how did it happen?							
If illness, has the patient suffered from the condition before?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please give the date of the first occurrence (dd/mm/yyyy):							
Name of medical practitioner who treated the patient while abroad:							
Address of medical practitioner:							
Email:							
Daytime phone:				Fax:			
Date(s) of treatment (dd/mm/yyyy):							
Was the patient hospitalised?						<input type="checkbox"/> Yes <input type="checkbox"/> No	
If yes, please give admission date (dd/mm/yyyy):				Discharge date (dd/mm/yyyy):			
Name and address of hospital:							

## Declaration

I declare that to the best of my knowledge and belief the statements made on this Claim form are full, true and complete.

Medical practitioner's/specialist's/therapist's signature:		Practice stamp:
Date (dd/mm/yyyy):		

**Section D: Medical expenses and repatriation – must be completed by the member/claimant**

Did you return to your home address on the intended date?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If no, when did you return (dd/mm/yyyy)?	
Who accompanied you?	
Did you call the 24-hour International Helpline?	<input type="checkbox"/> Yes <input type="checkbox"/> No

**Section E: Loss of deposits, cancellation and curtailment**

Date holiday booked (dd/mm/yyyy):
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Please attach original booking invoice and conditions/cancellation invoice.

Date of scheduled departure (dd/mm/yyyy):	Time of scheduled departure:
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Date of cancellation or curtailment (dd/mm/yyyy):
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Reason for cancellation or curtailment:
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Please attach original cancellation notice if applicable. If caused by illness, injury or death, section C needs to be completed or attach relevant medical report/copy of death certificate.

If the sick or injured person is someone other than the claimant, provide the following information:

Name:	Relationship to the claimant:
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Address:
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Type of expenses claimed:	Amount (including currency):
	Total:

**Section F: Travel delay/hijack**

Length of delay/hijack, specify how many hours:	Date(s) (dd/mm/yyyy):
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Departure point:	Flight number if relevant:
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Public transport carrier:	Cause of delay:
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Evidence (Irregularity Report) must be supplied by the provider of the public transport service to confirm the length and cause of the delay.

**Section G: Missed departure**

Reason for missed departure:
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Detail the expenses incurred:
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Type of expenses claimed:	Amount (including currency):
	Total:

Attach original receipts and provide evidence to support the reason you missed your departure.

**Section H: Loss/damage of money/delayed luggage**

Date of loss (dd/mm/yyyy):	Time of loss:
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Place of loss:
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Circumstances in which loss or damage occurred:
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Where and to whom was the loss or damage occurred:
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### Section H: Loss/damage of money/delayed luggage (continued)

Please attach the original Irregularity Report or Police Report and complete the following information:

Contact name:
Address:
Date loss reported (dd/mm/yyyy):
Name of household contents insurer and policy number:
Address of household contents insurer:

Give details of items lost/replaced. Continue on a separate sheet if needed. You must attach the original receipts with your claim.

Item:	Date of purchase:	Place of purchase:	Method of payment:	Owner's initials:	Amount (including currency):
Total:					

Give details of money lost or stolen:

Description (e.g. cash, traveller's cheques, etc.):	Value taken on trip:	Amount lost (including currency):
Total:		

### Section I: Loss of passport/travel documents

Give details of and reasons for expenses incurred and attach original receipts.

Type of expenses claimed:	Amount (including currency):
Total:	

**Section J: Payment details – must be completed**

Have you personally had to pay costs for what you are claiming for?  Yes  No

If 'Yes', and you are personally seeking reimbursement, you must tell us how you wish to be reimbursed by ticking either 1, 'Bank transfer' or 2, 'Foreign draft', and completing the required information.

We will only issue payment to:

- the claimant if they are 18 or over;
- the planholder if the claimant is under 18 and is a dependant under the plan; or
- the parent or legal guardian named as the planholder, if the claimant is the main member and is under 18.

If another person or entity has paid on your behalf please give their name:

Failure to complete all information for the chosen reimbursement method may result in you, the named person or entity:

- experiencing delays in receiving the claim settlement; and
- incurring additional bank charges.

1. Bank transfer – this is the quickest and safest method of payment

Name of account holder:

If the claimant's name (as given in section A) is different to the account holder name, please provide the following details:

Address of account holder:

Email address of account holder:

Telephone number of account holder:

**Bank account details:**

Bank name:

Bank address (including town and city):

BIC/SWIFT code:

Currency of bank account: Account number:

To help us direct your payments efficiently, supply the following as relevant:

IBAN number (mandatory for all payments to bank accounts in countries that have adopted IBAN):

Sort code (mandatory for UK located banks):

Routing Code/Branch Code (as available):

ABA number (mandatory for transfers to US located banks):

2. Foreign draft

Name to appear on the draft: Currency of the draft:

## Important information

Please remember these important points when completing your Claim form:

- Assessment of your claim may be delayed if you and your medical practitioner, specialist or therapist do not complete all the necessary sections of this form.
- Send your claim to us as soon as possible. We recommend that you do so within a maximum period of six (6) months of the first treatment date.
- Always send us the original invoices with this form. Photocopies, receipts and credit card statements will not be accepted.

## Section A – Claimant details

- If the claimant is a dependant under the age of 18, the main member must complete the form and sign the declaration for them. If the claimant is a member under the age of 18, the parent or legal guardian named as the planholder must complete the form and sign the declaration for them.

## Section H – Loss/damage of money/delayed luggage

- If you have a household contents insurance plan or policy that covers you for lost/damaged goods, we will need to know the details as it may affect the amount we pay in respect of your claim.

## Section J – Payment details

If you are not personally seeking reimbursement we will pay the treatment provider directly, as long as the payment instructions are shown clearly on the invoice. If you are personally seeking reimbursement, you need to tell us how you wish to be reimbursed.

- Ensure that you are able to receive payment in the method and currency you have requested.
- We reserve the right to pass on any payment charges incurred by us for cancelling the original payment due to inaccurate information submitted to us.
- We will not be responsible for any payment shortfall due to exchange rate fluctuations and/or bank service charges. Please contact your bank for further details.
- If you do not give us the sort code/routing code, BIC/SWIFT code and/or IBAN number, you may incur additional bank charges and it will result in a delay in us paying your claim. You can find the payment information on your bank statement.
- Payment by foreign draft in certain currencies can result in long delays. These delays are beyond our control. We will not pay any bank charges incurred in encashing a foreign draft. We strongly recommend that, wherever possible, you choose to be reimbursed by bank transfer as this is the quickest and safest method of payment.
- We can make payment in most readily traded currencies and to most countries. In the event that we are unable to make payment in the currency or to the country you have specified, we will contact you to confirm an alternative currency. If you do not specify a payment currency, we will pay your claim in the currency of your plan. For the current list of applicable currencies and countries please refer to our website.
- We cannot issue foreign drafts to banks based in Qatar.
- Your bank may ask you to complete additional paperwork before they can release our payment to you. This may delay your receipt of the payment and is outside our control.

## Section K

If the declaration has not been read and signed, we will not be able to process your claim.

## Excess

The standard excess for each claim will be deducted from any reimbursement.

## Checklist

There are two ways to send your claim to us:

1. By post – have you included:

- a fully completed Claim form with signed and dated declarations?
- original itemised invoices?

Photocopies, receipts and credit card statements are not acceptable. We are unable to return original documents, but are happy to provide certified copies on request.

- an original Irregularity Report from the airline and/or Police Report if you are claiming under sections F-I?

2. By email – have you read the scanned claims acceptance criteria?

You will find the criteria for accepting scanned claims in your Claims procedures or in the Members section at [www.interglobalpmi.com](http://www.interglobalpmi.com)

**Please call us on +44(0)1252 896 396 or email [igukclaims@aetna.com](mailto:igukclaims@aetna.com) if you require any further assistance.**

Send your claim to: Claims Team, Aetna Global Benefits (UK) Limited, 25 Templer Avenue, IQ Farnborough, Farnborough, Hampshire, GU14 6FE, United Kingdom. F +44 (0) 1252 745 921 W [www.interglobalpmi.com](http://www.interglobalpmi.com)

If coverage provided by this policy violates or will violate any United States (US), United Nations (UN), European Union (EU) or other applicable economic or trade sanctions, the coverage is immediately considered invalid. For example, Aetna companies cannot make payments or reimburse for health care or other claims or services if it violates a financial sanction regulation. This includes sanctions related to a blocked person or entity, or a country under sanction by the US, unless permitted under a valid written Office of Foreign Assets Control (OFAC) license. For more information on OFAC, visit [www.treasury.gov/resource-center/sanctions/Pages/default.aspx](http://www.treasury.gov/resource-center/sanctions/Pages/default.aspx).

Plans are underwritten by Aetna Insurance Company Limited, registered in England (Company Registration No. 05956141), which is authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority (Firm Reference No. 458505). Plans are administered on behalf of the insurer by Aetna Global Benefits (UK) Limited, registered in England (Company Registration No. 03554885), which is authorised and regulated by the Financial Conduct Authority (Firm Reference No. 312279). Both companies are registered at 50 Cannon Street, London, EC4N 6JJ, United Kingdom.

**Section K: Data Protection, Access to Medical Reports and Declaration – the Declaration must be signed by the claimant or the main member if the claimant is a dependant under the age of 18**

The words 'Aetna' and 'other Aetna entities' mean Aetna Global Benefits (UK) Limited and include any other Aetna International Inc. group company as the context requires.

**Data Protection Notice**

Aetna Global Benefits (UK) Limited ('Aetna', 'we') is the data controller of personal data collected and processed for the purposes set out in this document. Aetna considers personal data or personal 'information' to be confidential. We protect the privacy of that information in accordance with applicable privacy laws and regulations, as well as our own company privacy policies.

These laws and regulations include, but are not limited to, the Health Insurance Portability and Accountability Act Privacy Rules (HIPAA Privacy Rules), the General Data Protection Regulation (GDPR), the UK Data Protection Act 2018 and any applicable EU member state legislation and derogations.

We will use your personal data to determine eligibility and provide a quotation to you or to your broker; onboarding you to the plan, process payments, premiums and claims; managing, administering and improving your policy; investigating and responding to complaints; contact you with information about your plan and for the purposes of providing healthcare or wellness advice; fraud prevention together with any other regulatory checks; establish, exercise or defend legal claims or rights and to protect, exercise and enforce our rights, property or safety.

Where your health data is used for any of the above we rely on the insurance condition provided under the UK Data Protection Act 2018, which means we don't need to acquire your consent for the processing.

We retain your personal data for as long as necessary to provide you the benefits under your insurance plan, until such time as any claim under the insurance policy is concluded, until the limitation for exercising any legal rights has expired or for compliance with any legal or regulatory requirements. We may disclose information about you in various ways, including, but not limited to: health care operations, treatment, disclosure to other covered entities, plan administration, research, business associates, industry regulation, law enforcement, legal proceedings and public welfare.

In all situations other than those described above, we will ask for your written authorization before using or disclosing information about you.

We will not send any personal data or health information outside the EEA unless the appropriate protections are in place, or unless there are emergency medical ground for doing so.

To help us make sure that your personal information remains accurate and up-to-date, please inform us of any changes.

You have the right to access to your personal information, to request correction, erasure, restriction of processing, transfer of your information, and object to the processing of your personal data.

If you would like to exercise any of your rights relating to your personal data, or enquiry any further information, please contact our designated Data Protection Officer:

Data Protection Officer  
50 Cannon Street,  
London EC4N 6JJ  
United Kingdom  
Or  
dpo@aetna.com

You can find our full terms and conditions and details of our privacy policy at <https://www.aetnainternational.com/en/about-us/legal-notice.html>

**Access to Medical Reports Act 1988**

In order to process your claim, we may need to apply for a medical report from any medical practitioner that has attended you. We will require your consent before we can apply for this.

Under the law, you can:

1. Give your consent. If you choose this option, your medical practitioner will send the report direct to us.
2. Request to see the medical report before it is sent to us. If you choose this option, we will notify the medical practitioner of your request when we apply for your records. You must contact your medical practitioner within 21 days of our notifying you that we have requested a medical report about you to make arrangements to see the report. If you fail to make contact within 21 days, the medical practitioner will be entitled to send the medical report direct to us. You also have a right to request the correction of any information you believe is misleading or incorrect. After you have seen the report, you must give your consent before the medical practitioner can release the report to us.
3. You have a right to withhold your consent. Please note that if you choose this option, we may be unable to accept or process your claim.

You have a right to ask your medical practitioner for any report (whether or not you had previously requested to see it) we have requested within six months of its having been supplied to us. Your medical practitioner is entitled to withhold some or all of the information contained in the report if (a) he feels that it may be harmful to you or (b) it would indicate his intentions in respect of you or (c) would reveal the identity of another person without their consent (other than that provided by a health professional in their professional capacity in relation to your care). Your medical practitioner may also charge you for any of these services.

**Declaration**

I declare that all the details given on this Claim form are true and accurate and that I have not missed out any details important to this claim. I understand that if this claim is found to be fraudulent, in whole or part, I may be committing a criminal offence and that this may invalidate the plan and make me liable to prosecution. For this claim I authorise any medical practitioner, specialist, therapist or other relevant establishment who has attended me/the claimant in the past, or is attending me/the claimant at present, to give any details that may be asked for by the insurer or any authorised administrator. I confirm that I give explicit consent, within the provisions of the Data Protection Act 1998, (on behalf of myself and any family members specified in this form) for Aetna Insurance Company Limited (the insurer) to process our personal information with respect to our membership and I confirm that I have brought the Data Protection Notice to the attention of these family members.

(Our full terms and conditions and details of our privacy policy can be found at [www.interglobalpmi.com](http://www.interglobalpmi.com))

I authorise and request any hospital, specialist, physician or other health provider to furnish the insurer or its duly authorised agent acting on its behalf with such information as the insurer or such agent may seek from them in connection with any treatment or other services provided to me or my dependant/s for the purpose of the insurer considering this claim.

I have been advised of my rights under the Access to Medical Reports Act 1988.

I do (not)\* wish to see a copy of any medical report before it is sent to the insurer. (\*Delete the word NOT if you wish to see a copy of the medical report before it is sent to the insurer).

Claimant's/main member's signature:

Date (dd/mm/yyyy):