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

MAPFRE | ASSISTANCE
Agency Ireland

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

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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)

DATA PROTECTION

We will ask you to provide some specific information regarding the medical condition or injury giving rise to your claim, and also regarding current or past medical conditions for you and, where relevant, for your fellow travellers, close relatives or close business associate. We will only use sensitive information for the specific purpose you provide it, including to validate and administer your claim, and to provide the services described in the policy. This may include sharing with service providers, and if you have travelled outside the European Economic Area 'EEA', it may be necessary for us to transfer your data and share with service providers outside the EEA. Further information about how data is used and shared can be found in our privacy policy on www.mapfreassistance.ie/gdpr.
You must ensure that you only provide sensitive information about other people where you have the consent or legal right to do so.

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☐
Private Health Insurance? 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

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information from other insurers and third parties to check that the information provided above is truthful and that details of this claim can be used for audit and fraud prevention 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

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:____

We may need to forward your EHIC to the treating facility please sign your consent: ______________________
Please provide details of your Private Health Insurer and policy number: ____________________

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:_______________________________

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. You must ensure that you only provide sensitive information about other people where you have the consent or the legal right to do so.

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. I confirm that I have obtained the explicit consent of the data subject to share this information for the purposes of validating and administering the claim.

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

Signature: _________________________

Date: _______________________

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