Chubb European Group SE
Travel Insurance Claims
Sedgwick, Merrion Hall,
Strand Road,
Sandymount, Dublin 4

Telephone: 1800 719 420 or
+353 (0)1 440 1757

# Claim form
# Personal Accident/Sickness

## Data protection

We use personal information which you supply to us [or, where applicable, to your insurance broker] for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: https://www2.chubb.com/ie-en/footer/privacy-policy.aspx or by searching 'Master Privacy Policy' on https://www2.chubb.com/ie-en/. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

**Please write in black ink and use block capital letters.**
All sections must be completed or marked 'not applicable'.
Complete the checklist and ensure that you sign the declaration at the end of this form.
Once completed please email to travel@ie.sedgwick.com and include any supporting documentation.

## Policy number

## Main Policy holder details

**Title** | **First name** | **Last name**

**Email address** | **Date of Birth (DD/MM/YY)**

**Full address**

**Post code**

**Contact no. (day)** | **Contact no. (eve)**

## Insured persons details

| Full name | Date of Birth (DD/MM/YY) | Relationship to main policy holder | I intend to claim on behalf of: (✓) where applicable |
|---|---|---|---|
| Main Policyholder as above | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |
| | | | ☐ |

## Employment details

What is your occupation?

Please describe your duties:

Name & Address of employer:

Email address of employer:

Please state average annual gross and net salary over previous 12 months from the date of the incident (please enclose copies of 13 weeks pay slips prior to the event) or over the previous 36 months from the date of accident if self employed (please provide evidence of income by means of Inland Revenue Tax Assessment forms or audited accounts):

Gross: Net:

## Accident/Sickness details

Please give exact date and time when injured or taken ill: Date: Time: am /pm

Please state

a) The date you ceased working:

b) The date you returned to work:

c) If you have not returned to work, on which date do you hope to do so?:

If **accident** please state fully:-

a) Where the accident occurred:

b) How the accident occurred:

c) The injuries sustained:

If illness please state full details of your illness:

Has the patient ever suffered with this or any similar condition before the present episode? Yes: ☐ No: ☐

If Yes, please give details

Have you previously claimed under this or a similar policy? Yes: ☐ No: ☐

If Yes, please give details

Please give the name, address and policy number of any other insurance that may cover this injury

## Hospital statement – only to be completed if claiming hospitalisation benefit

This section must be fully completed by hospital medical staff or records – any fee for completion of this section is the responsibility of the beneficiary of insurance

a) Type of hospital/ward _____

b) Name of Doctor or Consultant in charge _____

c) The dates admitted and released Admitted: _____ Released: _____

d) Was any period spent in Intensive Care Yes ☐ No ☐ From: _____ To: _____

e) Was the patient subsequently confined to their home on medical grounds? Yes ☐ No ☐

If **Yes**, please give dates From: _____ To: _____

Is there any additional information that you feel is relevant

**Signed** **Date**

Position held in Hospital: Qualifications:

**Please use validation stamp or complete in block capitals:-**

Validation stamp

Hospital Name: _____

Address: _____

_____

Telephone No: _____

Thank you for your assistance in completing this form.

## Doctor's statement

This section must be fully completed by attending doctor – any fee for completion of this section is the responsibility of the beneficiary of insurance

Patient's Name: (Mr, Mrs, Miss, Ms) _____

Date of Birth: _____ Height: _____ Weight:

Please give full details of injury/illness:

Final diagnosis:

When did the patient first receive medical attention for this condition?

Has the patient ever suffered with this or any similar condition before the present episode? Yes ☐ No ☐

If **Yes**, please give details including dates treatment and consultation:

Are you the patient's usual Doctor: Yes ☐ No ☐

If **No** please give name and address of usual Doctor

On what date did incapacity commence?

Is patient still incapacitated? Yes ☐ No ☐

If YES when will patient be able to return to work? _____

If NO when did incapacity cease?

Was the patient hospitalised as a result of this condition? Yes ☐ No ☐

Is there any additional information that you feel is relevant? _____

**Signed:** _____ **Date:** _____

**Name:** _____ Qualifications: _____

Position held in Hospital: _____

**Please use validation stamp or complete in block capitals:-**

Validation stamp

Name: _____

Address: _____

Telephone No: _____

Thank you for your assistance in completing this form.

## Explicit Consent to use Health Information- Important Please Read

*We carefully assess your claim, and also take steps, in common with standard industry practice, to monitor for fraudulent claims. For these reasons, we may need to use information about your health which is relevant to your claim, and, where relevant, the health of other persons relevant to the claim which you provide to us.* ***You must ensure that any other persons whose information you provide to us understand and do not object to this use of their data, and (where required under applicable law) consent to us using their information for the purposes described here****.*

*We will not use this health information for any other purpose, and will comply at all times with the terms (including security standards) referred in our Privacy Policy. You do not have to provide us with the following consent, and you may withdraw it at any time, but if you do not provide it, or choose to later withdraw it, that may affect our ability to process your claim.*

***Please tick the following box to indicate your consent to our use of your health information in this way.*** ☐

## Payee's bank details

If we approve your claim, we can credit the money direct to your bank account. This method is quicker, safer and more reliable than payment by cheque. If you would like us to do this, please complete the following:-

Name of your Bank/Building Society: _____

Address: _____

_____

_____

_____

Postcode: _____

Bank Sort Code ☐☐ ☐☐ ☐☐

IBAN _____

BIC _____

Account Number _____

Name of Account Holder (s) _____

## Declaration

I declare that all the information given is to the best of my knowledge and belief, full true and correct.
I give permission for any Medical Practitioner, Law Enforcement Agency or Statutory/Regulatory Authority mentioned with respect to this claim, to release information regarding my records.

**Signed** _____

**Name:** _____ **Date:** _____

## Checklist

Please return the completed claim form together with any enclosures to your insurance broker or to Chubb European Group SE and please ensure:

- ☐ You fully complete every question **before** your doctor completes his statement
- ☐ You have enclosed all requested original documents (we recommend you retain copies)
- ☐ You have signed this claim form
- ☐ Your attending doctor fully completes the statement

If you do not complete all sections and provide all requested documentation your claim will be delayed.

Chubb. Insured.℠