



MEDICAL EXPENSES / CURTAILMENT CLAIM FORM

Please submit your claim to
claims@optimumglobal.com

The insured member is required to complete the following claim form and attach all the original medical bills and supporting documentation when filing the claim.

Personal Data provided in this claim form or submitted as part of this claim will be used and processed by us in line with our Privacy Policy which can be found on our website, or which can be requested from us at any time.

SECTION A: PATIENT DETAILS TO BE COMPLETED BY INSURED MEMBER

Name of Main Applicant:	Membership No.:	Date of Birth:	Sex:
_____	_____	_____	_____
Name of Patient (If other than the main Applicant):	Membership No.:	Date of Birth:	Sex:
_____	_____	_____	_____
Present Contact Address:			

Telephone number:	Email Address for Remittance Advice:		
_____	_____		

SECTION B: SETTLEMENT DETAILS

We settle all eligible claims by bank transfer (EFT), therefore it is important that you confirm your correct bank details every time you make a claim. Should the incorrect bank details be provided we reserve the right to charge an administrative fee to cover any charges incurred due to the error.

Total amount claimed (including currency): _____

Currency of Reimbursement: _____

Bank Transfer – **All fields in the box below are MANDATORY. If the account holder is not the claimant then you must state their relationship with the claimant and provide evidence of their permission for the funds to be transferred to their account (except in the case of a minor):**

Name of Account Holder (as it appears on bank statement):	_____
Relationship to claimant	_____
IBAN where applicable	_____
Routing/intermediary information if required	_____
Beneficiary Bank Account number (only if IBAN not applicable)	_____
Account Holder address (residential address registered with the bank):	_____
_____	_____
Name of Bank, Branch and Location:	_____
Swift Code/BIC:	_____ Sort Code (for UK banks only): _____

PLEASE NOTE:

- **Bank charges may apply when making bank transfers.**
- **Payments are not made directly to any clinic, physician or medical provider.**
- **If IBAN numbers are not used please ensure that the account number is entered and that the Swift Code/BIC is also completed.**

DECLARATION & AUTHORISATION

(This part must be signed by the patient or patient's parent/legal guardian if the patient is below 18 years of age)

I hereby authorise any hospital, physician, person or organisation to disclose all information with respect to any illness, injury, medical history, consultations, prescriptions or treatment, and copies of all hospital or medical records. A photostat copy of this authorisation shall be considered as effective and valid as the original.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Main Applicant _____ Date _____ Signature of Patient _____ Date _____



SECTION C: TRAVEL DETAILS

Travel Destination:

Country: _____

Hotel: _____

Departure Date: ____/____/____ Return Date: ____/____/____

Purpose of Trip: Business Pleasure

SECTION D: CLAIM DETAILS

Date, time and place of illness/injury: ____/____/____ : ____ AM PM

Illness suffered or injuries sustained: _____

If injury, please provide full circumstances of the incident: _____

Have you suffered from a similar condition before? Yes No

If yes, please ask your doctor to complete the Medical Certificate attached.

Did you contact the Emergency Medical Assistance Company? Yes No

If yes, please provide the reference number given to you: _____

Were you hospitalised as an in-patient? If so, please provide:

Date admitted: ____/____/____ Date discharged: ____/____/____

Time admitted: ____:____ AM PM Time discharged: ____:____ AM PM

If applicable, period of extended accommodation: ____/____/____ to ____/____/____

Did you return home early? Yes No

If yes, please provide the date on which you returned: ____/____/____

Do you hold any other insurance that may cover this loss? Yes No

(i.e. Private Health, Bank Account, Credit Card, Tour Operator)

If yes, please give details: _____



**SECTION F: GUIDANCE NOTES**

The following documentation must be provided in order for your claim to be processed.

ITEM	ENCLOSED
Your original booking invoice which is sent to you at the time of booking your trip _____	<input type="checkbox"/>
Evidence to support your claim _____ Original receipts/invoices for expenses being claimed Hospital/Doctor reports/records	<input type="checkbox"/>
If you returned home early: _____ Confirmation from the treating Doctor of the medical necessity to return early, or if the return was as a result of an illness/death of a relative we require the medical certificate attached to be completed by the usual Doctor of the person causing curtailment.	<input type="checkbox"/>
For Medical Expenses incurred in the EU only, please complete the attached disclaimer _____	<input type="checkbox"/>
If the expenses are a result of an incident: _____ Copies of any Police reports Details of the Third Party's insurance company Details of any solicitor that you may have appointed to handle a Personal Injury Claim	<input type="checkbox"/>
If you have submitted a claim to another insurance company or third party: _____ Copies of all correspondence	<input type="checkbox"/>