Travel Claim Form

Talent Trust Consultants

Primary Insured Details

Full Name:		Date of Birth:	day / month / year
Member ID/Cert Number:		Telehone:	
Email:		Fax:	
Mailing Address: *Compulsory			

Travel Provider Details

Tour Operator:		Address:	
Date Outbound:	day / month / year	Date Inbound:	day / month / year
Countries Visited:	1	2	3

Complete for: Loss or Theft of Money or Passport

Date of Loss/Theft:	day / month / year	Police Report Number:	
Time of Loss/Theft:		Police Station Address:	
Place of Loss/Theft:			
Describe how loss occured:			

Please ensure that the original of the Police Report is attached — your claim will be invalid without it.

Money

Who owned the money	Currency	Total Claimed	Where was money obtained	Date obtained

Please provide proof of original currency purchase.

Passport

Passport Holder	Date of Issue	Place of Issue	Original Cost	Replacement Cost

Please provide proof of replacement cost.

Complete for: Loss or Theft of Personal Effects or Delayed Baggage

Date of Loss/Theft:	day / month / year	Police Report Number:	
Time of Loss/Theft:		Police Station Address:	
Date Returned:	day / month / year		
Place of Loss:		Contact:	
Address:		Contact's Telephone:	
Describe how loss occured:			

Please ensure that the original of the Police Report is attached — your claim will be invalid without it.

Item(s)	Description	Place Purchased	Date Purchased	Original Cost	Method of Purchase

1. For loss/Theft claims attach original proof of purchase.
2. For 'Baggage Delay' attach receipts for items purchased & carrier report showing details of delay.

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Complete for: Cancellation or Curtailment

Date Cancelled:	day	month	year	(Delay) Place:	
Date Returned Home:	day	month	year	(Delay) Duration:	hours / minutes
Describe cause of cancellation/ curtailment/delay:					
Name of party causing loss:				Relationship to Insured:	
Original ticket cost:				Accomodation Cost:	
Reimbursement due:				(Curtailment) Lost days:	
Additional Expenses incurred (description & cost):	1 2 3 4			Reason for additional expenses:	

Please ensure that the original of invoices for additional expenses are attached.
Please ensure that any information in support of the reasons for cancellation or curtailment are attached.

Complete for: Cancellation or Curtailment due to Medical Reasons

Name of injured party:				Relationship to Insured:	
Date of Birth:	day	month	year	Duration of disability:	start date / end date
Nature of illness or injury (if injury, please give full details including date and place):					

Complete for: Hospital Benefit (Outreach customer only)

Date of Admission:	day	month	year	Time of Admission:	
Date of Discharge:	day	month	year	Time of Discharge:	

Please ensure that you attach a hospital invoice detailing the period of admission, including times of admission and discharge.

Medical Certificate

To be completed by attending Physician only. *Please note that any fee for the completion of this is the responsibility of the claimant.*

Name patient:				Date of Birth:	day / month / year
First date of symtoms:	day	month	year	First date of treatment:	day / month / year
First treated by whom:				Date first seen by you:	day / month / year
Diagnosis:				Prognosis:	
Medical history of this or any related condition:					

If due to pregnancy please provide

Date of LMP:	day	month	year	Date of confirmation:	day / month / year
Est Date of confinement:	day	month	year		

Physician's Details

Physician's Name:		Telephone:	
Contact Email:		Fax:	
Address:		Official Stamp:	
Date completed: day / month / year		Signature:	

Authorisations, Releases and Declarations

To be completed by the Claimant

Access to Medical Report

Before we can apply for medical report from a Doctor who had cared for you, we need your consent by signing below. Before doing so, however, you should read this note carefully. You do not have to give your consent but, if you do, you can say whether you wish to see the report before it is sent to us. If you do not give consent, this may affect our ability to assess your claim.

If you say you do not wish to see the report, we do not have to notify you if we apply for one. However, if, before such a report is sent to us, you change your mind, you can write to the Doctor saying you wish to see it, you will then have 21 days to contact the Doctor about arrangements for you to see the report.

If you say you wish to see the report, we will tell you at the same time as we write to the Doctor, and we will tell him you wish to see the report. You will then have 21 days to contact the Doctor about arrangements for you to see the report. Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied, if you ask. If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his costs.

Once you have seen a report before it is sent to us, the Doctor cannot submit it until he has your consent. You can write to the Doctor, asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your views on any part where you and the Doctor are not in agreement and which the Doctor is not prepared to alter.

The Doctor is not obliged to let you see any part of a report it, in his opinion that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctor's intentions towards you, or if disclosure would be likely to reveal information about you, or identity of another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional involved in caring for you. In such cases, the Doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report, which is accepted, he must not send it to us unless you give your consent.

Signed:

Dated: day month year

I do not wish to see any medical report *

I do wish to see any medical report *

* Tick as appropriate

(If claimant is under 18, parent or guardian must sign)

Other Insurance

Do you, or another member of the party involved in the claim, hold other insurance which may respond:

Policy Number:

Contact Telephone:

Have you made a claim:

Claim Number:

Insurer:

Address:

Amount claimed:

Authorisation & Declaration

I AUTHORISE any insurance company, physician, hospital, and other health care providers, any travel organization or agency, airline carrier, rental agency, hotel, motel, or similar entity providing lodging on a rental/lease basis or any other person who may have knowledge regarding this claim, to release any information requested regarding this claim and the loss reported.

I UNDERSTAND that Travel Benefits Plan, administered by TTc, does not cover losses caused by injury or sickness to the extent that they are eligible under a primary group insurance, group-type insurance, prepayment, group practice or individual practice coverage and coverage other than school accident-type coverage, now therefore, as a condition for my receipt of immediate benefits under the plan, for claims in connection with injury or sickness beginning on the date shown above, I irrevocably agreed to: (a) assign all benefits payable from my primary insurer to TTc; (b) promptly reimburse TTc if and when I receive payment(s) from my primary insurance; (c) allow TTc to file a claim with my primary insurer to receive direct reimbursement; and (d) when requested by TTc, to furnish TTc with copies of my primary insurer's schedule of benefits.

I UNDERSTAND the information obtained by use of the authorisation, will be used by TTc to determine eligibility for benefits under this plan. Any information obtained will not be released to any person or organization EXCEPT to reinsuring companies, or other persons or organizations performing business or legal services in connection with my claim, or in accordance with Fraud Prevention and Detection, or as may be otherwise lawfully required or as I further authorise.

I KNOW that I may request to receive a copy of the Authorisation. I AGREE that a photographic copy of this authorisation is as valid as the original. I AGREE that this Authorisation shall be valid for two and one half years from the date shown below.

I declare that the information provided in this claim is, to the best of my knowledge, a fair and accurate reflection of the circumstance of my claim.

I UNDERSTAND that any misrepresentation will result in my cover being cancelled in full, without refund of premium. I understand that legal proceedings will be brought against me in the event of any proven fraudulent application for benefit.

Fraud Prevention and Detection: In order to prevent and detect fraud we may at any time share personal information about you with other insurers or financial institutions; check your details with fraud prevention agencies. If you give us false or inaccurate information and we suspect fraud we will record this and pass this information to fraud prevention agencies.

Signed:

Dated: day month year

(If claimant is under 18, parent or guardian must sign)

Payment Instructions

Complete for: Cheque Settlement

Payee:

Contact Telephone:

Email Address:

Currency for Settlement:

Address:

Complete for: Bank Transfer Settlement

Account Holder's Name:

Bank Name:

Account Number:

Routing/Sort Code:

Swift Code:

Currency for Settlement:

Address:

IBAN No:

Account Type:

Check List

When returning the claim form, please ensure that all necessary supporting information is attached. Where there is insufficient information to substantiate your loss, your claim may be reduced or declined.

- ☑ Travel tickets (used or unused)
- ☑ Travel agents invoice
- ☑ Proof of withdrawal for Money/foreign currency claim
- ☑ Traveller's checks should be refunded by issuing office, if not provide evidence as to why no refund
- ☑ Police report – showing time and date of loss within 24 hours of loss (Money/theft/loss claims)
- ☑ Carrier report – showing date of loss/delay (Baggage claims)
- ☑ Tradesman's invoice for cost of repair and detail of repair. Invoice for replacement item (if applies)
- ☑ Ticket/accommodation receipts for additional expense (Cancellation/curtailment claims)
- ☑ Hospital Discharge summary (Medical/Hospital claims)
- ☑ Carrier Report, police report, public transport report showing reason and length of delay
- ☑ Please complete the attached Payment Instruction form

All claim forms for medical treatment and non-medical claims should be sent to:

- When scanning and sending files, please ensure to use lower resolution and smaller file sizes. Aetna's email system will not accept emails larger than 8Mb. If an email larger than 8Mb is sent it will not be received to be processed. For more details on submitting claims please refer to **http://www.talent-trust.com/claims/**
- A separate claim form and all supporting documentation (as a set) must be submitted for each Medical Condition and/or Claimant.
- All claim forms for medical treatment and non-medical claims should be sent to **claims@talent-trust.com**
- For claims related queries please contact our 24 hour Member Services helpline **+ 1 (877) 248 2197**

IMPORTANT - TREATMENT RECEIVED IN THE USA

All Services and Treatment must be pre-approved by *our Medical Helpline* and received at an approved Preferred Provider Network facility. To obtain a list of approved PPO Network Providers contact the Claims Administrator or view the approved listing on **http://www.talent-trust.com/ppo-network/**

To obtain pre-approval please contact the Medical Helpline :
+ 1 (877) 248 2197