

Dear Claimant,

**Re: Medical Expenses / Curtailment Insurance Claim**

We are sorry that an incident has occurred during your trip. Please find attached a claim form. Please ensure this is fully completed, signed and returned to us by post, together with the following original documentation.

1. Proof of your insurance. This may be in the form of a holiday booking invoice or for Internet bookings, an email confirmation.
2. The Airlines booking invoice or proof of travel and payment of trip.
3. Original receipts/invoices in respect of the amounts being claimed.
4. All Travel tickets - used and unused.
5. A letter from the treating doctor confirming dates of admission and discharge.
6. For curtailment claims, written confirmation from the treating doctor that such curtailment was medically necessary.
7. Where necessary, a medical certificate may require completion. If necessary, this will be sent after your claim has received an initial assessment.

If any of the above cannot be provided, please enclose a covering letter explaining the reasons for this.

Please note that in order for us to handle your claim as quickly and efficiently as possible, it is necessary that you answer all questions and forward original documents. We suggest that you retain copies for your records. **Please ensure you make it clear who you wish any payment to be made out to if not the claimant.**

The address to return your completed claim form and supporting documentation to is as follows:

Travel Claims Department  
Arab Gulf Health Services  
NEXtCARE, Eiffel Boulevard Limited Building  
(Eiffel 2) 1<sup>st</sup> floor, Umm Al Sheif  
Sheikh Zayed Road  
PO80864  
Dubai UAE  
Phone: **UAE +971 4 270 8705**  
Email: [travel.claims@nextcarehealth.com](mailto:travel.claims@nextcarehealth.com)

We look forward to hearing from you.

Yours faithfully,

**Travel Claims Department**  
NEXtCARE

**CLAIM FORM**

Please ensure all original documents requested are enclosed

Claim Reference No.:

**Personal Details**

Surname:	<input type="text"/>	Forename(s):	<input type="text"/>
Title:	<input type="text"/>	Date of Birth:	<input type="text"/>
Address:		<input type="text"/>	
Occupation:	<input type="text"/>	<input type="text"/>	
Daytime Tel No:	<input type="text"/>	Postcode:	<input type="text"/>
Evening Tel No:	<input type="text"/>	Mobile No:	<input type="text"/>
E-mail Address:	<input type="text"/>		
Cheque to be made payable to:	<input type="text"/>		

**Trip Details**

Destination / Country of this Journey:		<input type="text"/>	
Date Journey Booked:	<input type="text"/>	Date Insurance Purchased:	<input type="text"/>
Date of Journey:	<input type="text"/>	Date of Return:	<input type="text"/>
Duration: days	<input type="text"/>	No. of People Insured:	<input type="text"/>
Place Insurance Purchased:		<input type="text"/>	
Name of Tour Operator (if applicable): <input type="text"/>			

**Travel Insurance Details**

Travel Insurance Policy No/Ref:		<input type="text"/>	
What company did you buy your Travel Insurance from?		<input type="text"/>	
Other Insurance: Please confirm which Bank you hold current accounts and / or credit cards with:			
Bank Name	<input type="text"/>	Credit Card No.	<input type="text"/>
		Issued Bank	<input type="text"/>
		Date of Expiry	<input type="text"/>

[illegible]

Do you have any private medical Insurance? Yes : ☐ No: ☐

If yes:

Name of Company :  Address:

Policy Number:

**Curtailment (cutting short your trip) claims only**

For claims due to death or illness Outside your country of **residence**, Please Confirm the name of the persons and relationship to the claimant.

Name:  Relationship:

If you did not contact us for medical assistance prior to curtailing (cutting short your trip), please explain the reasons for this

Name of persons curtailing (cutting short the trip)	Total holiday cost per person less insurance premium

Date of returned:  Date you should have returned:  No. days missed

**Declaration:** Insurers and their agents share information to prevent fraud and for underwriting purposes. It is a criminal offence to make a fraudulent claim. Cases are investigated and any person suspected of fraud is reported to the police with whom we always co-operate in effecting a prosecution. I/We declare that the information contained within this claim form is true and correct to the best of my/our belief. I/We assign to Insurers all rights of recovery/salvage against any person or organization and will do whatever else is necessary to secure such rights. I/We agree that Insurers may contact our *family or treating doctor* for more information if they deem it necessary.

Printed name:  Signature:  Date: