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, together with the following supporting documents. We require:

1. The Airlines booking invoice or proof of travel and payment of trip.
2. Invoices in respect of the amounts being claimed.
3. All Travel tickets - used and unused.
4. A letter from the treating doctor confirming dates of admission and discharge.
5. For curtailment claims, written confirmation from the treating doctor that such curtailment was medically necessary.
6. 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 all supporting documents. We suggest that you retain copies for your records.

Please contact us on telephone UAE +971 4270 8705 or email: travel.claims@nextcarehealth.com

We look forward to hearing from you.
Yours faithfully,
Travel Claims Department

Consent Form

We care about your privacy and the privacy of your family members. In line with the General Data Protection Regulation (GDPR), we need your consent to collect and process your health and other data. **If you do not provide your explicit consent for the processing of your personal data as outlined below, we will not be able to handle your data, provide cashless access to treatment or process any claims that may be owed to you. For more information, please have a look at our privacy notice.**

If you agree, your data will be processed for the following reasons and activities.

The table below needs to be completed only by those members under this policy who have not already provided consent before. Their consent will be valid for the entire duration of their policy unless they decide to change or revoke at any time.

A parent or guardian should complete the consent for any member that is under the age of 18.

By signing this form I agree to the following:

1. **Permission to collect, store and use my health data:** my data is being collected, stored and used in order to administer the policy or process any claims in compliance with the local regulations.

2. **Permission to obtain my data from third parties:** my health and other data may be obtained from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my Plan Sponsor, professional associations and public authorities to provide me with insurance cover or process any claims. I agree to release all individuals at these institutions and the health insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for these aforementioned stated purposes.

3. **Sharing my data: m**y health data may be shared with the institutions set out below for them to use to the same extent, and for the same purposes as the health insurer. I understand that the health insurer has put in place contractual arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and the health insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for the purposes set out below:
    - With independent medical experts if this is necessary to process my claim as per my insurance policy.
    - With service providers that perform certain services on behalf of the health insurer, such as claims handling that involve the collection and use of my health and other data, without which the health insurer would not be able to administer my policy or pay any claims due to me.
    - With other health insurers/re-insurers that may be covering the same insurance risk at the same time – multiple insurance – to distribute the payment of any compensation that may be owed to me, or to collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let the health insurer know by emailing: Dataprivacy@nextcarehealth.com

Personal Details

Surname: Forename(s):

Title: Date of Birth Address:

Mobile No: Email:

Trip Details

Destination/Country of this Journey:

Date Journey Booked :

MEDICAL EXPENSES, HOSPITAL BENEFIT AND CURTAILMENT CLAIM FORM

Details of injury/ illness

Please advise the exact nature of the injury or illness giving rise to this claim.

Date: Time: Place: Country:

Circumstances::

Has treatment been sought for this or any other related illness in the past? If yes, Please provide details.

We may wish to contact your family or treating doctor in your home country.

Please confirm this is acceptable. Yes No Name of family or treating doctor:

Address:

Please complete below and forward original receipts:

Type of expenses, e.g. Doctors fee, pharmacy costs etc	Name of Provider, e.g. Doctors, Hospitals etc	Currency used and amount	Please indicate if bills are	
			Paid	Unpaid

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

If yes: Name and address of the Company:

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

Claimant Name: Signature: Date:

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.