NEXtCARE®
Your Health Managed with Care

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) – First Floor

Sheikh Zayed Road, Near the First Gulf Bank Metro Station

Umm Al Sheif
PO80864, Dubai UAE
Ph: **UAE +971 42708705**
Email: **travel.claims@nextcarehealth.com**

We look forward to hearing from you.

Yours faithfully,
Travel Claims Department
NEXtCARE

NEXtCARE®
Your Health Managed with Care

CLAIM FORM

Please ensure all original documents requested are enclosed

Claim Reference No.:

Personal Details

Surname:

Forename(s):

Title:

Date of Birth:

Address:

Occupation:

Daytime Tel No:

Postcode:

Evening Tel No:

Mobile No:

E-mail Address:

Cheque to be made payable to:

Trip Details

Destination / Country of this Journey:

Date Journey Booked:

Date Insurance Purchased:

Date of Journey:

Date of Return:

Duration: days

No. of People Insured:

Place Insurance Purchased:

Name of Tour Operator (if applicable):

Travel Insurance Details

Travel Insurance Policy No/Ref:

What company did you buy your Travel Insurance from?

Other Insurance: Please confirm which Bank you hold current accounts and / or credit cards with:

Bank Name

Credit Card No.

Issued Bank

Date of Expiry

NEXtCARE®
Your Health Managed with Care

MEDICAL EXPENSES, HOSPITAL BENEFIT AND CURTAILMENT CLAIM FORM

Please ensure all original documents requested are enclosed Claim Reference No.:

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.

Did you contact us for medical assistance? Yes: No: Reference No.:

Assistance provided :

If you were admitted to hospital , please provide details :

Name of hospital : Date admitted :

Date discharged :

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* : Tel No.:

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

NEXtCARE®
Your Health Managed with Care

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: ______