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HEALTH INSURANCE CLAIM FORM

IMPORTANT: Please complete form in full, failure to do so may delay payment of claim. Please use **BLOCK** letters. Proof of claim must be submitted within 90 days of first of accident of illness. In order for your health claim to be considered for reimbursement, you must complete and sign this claim form. Please mail or fax this completed claim form with itemized bills and receipts to the address or fax listed above.

When mailing, please tape small receipts to a letter or A4 paper. Please do not staple receipts to claim form. A separate claim form should be used for each patient and each medical condition.

Documents and signed claim forms can be scanned and emailed to: healthcare@lampinsurance.com

Duration of trip: Date of departure __________ Date of return __________
Purpose of trip: ❍ leisure ❍ work ❍ education

Information of Insured:

Policy number: __________
First name(s): __________ Date of birth (day/month/year): __________
Family name(s): __________ Sex: ❍ Male ❍ Female
Address: __________
City: __________ Postal Code: __________
Country: __________ Main contact number: __________
Email: __________
Student Travel Organisation: __________

Information about the claim:

This claim is for: ❍ illness ❍ injury ❍ accident ❍ other
Where did the illness/injury/accident occur? __________ Date: __________
How did it take place? __________

In case of illness/injury:

Please include a medical report stating the diagnosis and give your own full description of the course of the illness/injury (date of first symptom, etc.):

If you need extra space to give a full description, please continue on a blank piece of paper.

Have you previously had similar symptoms? ❍ Yes ❍ No
If yes, which symptoms and when? __________
Name of your doctor: __________
Address: __________
Telephone: __________

In case of accident:

Please include a police report and describe the situation with your own words: __________

If you need extra space to give a full description, please continue on a blank piece of paper.

Names and addresses of witnesses (if any): __________

In case of treatment by a doctor:

Date(s) of treatment: __________ Name of doctor: __________
Address: __________
Telephone: __________ Fax: __________
Email: __________

Please include all information from the doctor together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

LAMP Insurance Company Limited – registered in Gibraltar – company number 93562. Registered Office: First Floor, Grand Ocean Plaza, Ocean Village, Gibraltar
LAMP Insurance Company Limited is licensed by the Chief Executive of the Gibraltar Financial Services Commission under the Insurance Companies Ordinance
LAMP Services Limited – registered in England and Wales – company number 04967967. Chester House, Harlands Road, Haywards Heath, RH16 1LR
LAMP Services Limited is authorised and regulated by the Financial Services Authority. FSA registration number 435979.

In case of treatment at a hospital or an emergency room:

Date treatment began: ______________________ Date of discharge: ______________________

Name of hospital: ______________________

Name of treating doctor: ______________________

Address: ______________________

Telephone: ______________________ Fax: ______________________

Email: ______________________

Kindly include all information from the hospital together with the original and receipted bills. The bills must state the dates of treatment and specify each individual amount.

Specification of expenses (if bills are included):

Amount in local currency: ______________________

Amount in reimbursement currency: ______________________

Please include all the original bills and a list where you specify the expenses.

Reimbursement:

Please include the original itemised and receipted bills and travel documentation

Payments are made in USD dollars unless other currency is requested and are subject to USD Exchange Rate of date service rendered.

The amount should be reimbursed to: ❍ Policyholder ❍ Other

Amount: ______________________ Currency: ______________________

❍ Please transfer reimbursement to my credit card ❍ Visa ❍ Eurocard/MasterCard ❍ JCB

Card number: ______________________ Expiry date (mm/yy): ______________________

❍ Please transfer reimbursement to my account

Name of bank: ______________________

Address: ______________________

BIC/S.W.I.F.T Code/ABA, if any: ______________________

IBAN: ______________________

Account number: ______________________

Account holder: ______________________

Information about other insurance:

Do you have similar insurance with another company? ❍ Yes ❍ No

If yes, name of company: ______________________

Address: ______________________

Policy number: ______________________ Has this claim been reported to the other company? ❍ Yes ❍ No

Policy holder or authorised person’s Signature and Release (to be completed by the Parent or Legal Guardian if claim is for a minor):

I certify, to the best of my knowledge, that this Claim Form does not contain any false misleading or incomplete information. I authorise the release of all records or other information that may be necessary to determine benefits payable.

Signature: ______________________ Date: ______________________

Print name: ______________________

Are you the insured: ❍ Yes ❍ No If no, relationship to insured: ______________________