Travel Claim Form

Travel Claim Form

Please complete this form and sign. Please provide further information on a separate sheet if necessary. Failure to disclose all material information and/or misrepresentation could result in your insurance being declared void by the insurer and a claim being rejected. When complete, please send this form via email to submitclaim@bfm.bm, or fax it to 295-8647, or return it by hand to BF&M's main office in the Insurance Building on Pitts Bay Road, Pembroke.

1. Claimant details

All questions in this section must be answered

Name of policy holder(s)	Name of claimant
Policy number	Date of Birth (DD/MM/YY)
Address	
Home phone	Work phone
Mobile phone	Email
Travel agent if used	Date booking travel arrangements (DD/MM/YY)
Date of departure (DD/MM/YY)	Date of return (DD/MM/YY)

Provide your Bermuda dollar bank details below for a direct deposit to your bank account. Please note we cannot deposit into a credit card account. Payment will be less any applicable excess.

Name of bank	Account name	Account number

2. Travel arrangements

Did you use a credit card to purchase your travel (e.g. flights, accommodation, tours) ☐ Yes ☐ No	
If yes, name on credit card	Name of financial institution
Card type ☐ Visa ☐ Master Card ☐ Amex ☐ Other	

3. Claim information

Please tick all the applicable box(s) relating to your claim type and answer the appropriate section.

☐ A. Personal accident
☐ B. Cancellation
☐ C. Medical and emergency travel expenses
☐ D. Personal property
☐ E. Delayed luggage expenses claim

A. Personal accident

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance
2. Medical/Hospital/Dental Report detailing Treatment and Diagnosis
3. Itemised accounts giving a breakdown and description of costs claimed, together with receipts if any accounts have been paid by you
4. Completed Medical Certificate

Failure to provide these documents may result in delays in processing your claim.

Type of injury or sickness	Date of accident/sickness (DD/MM/YY)
If injury, give full details of accident	
Date of first medical consultation (DD/MM/YY)	Name of doctor, dentist or hospital
Details of other treatment by doctor, dentist or hospital	
Hospital admitted date (DD/MM/YY)	Hospital discharge date (DD/MM/YY)
Have you ever suffered from the same or similar injury or sickness in the past	☐ Yes ☐ No
If yes, give details including dates, names and addresses of treating physicians	
Health insurer	Name of family doctor

Please list each receipt/bill separately in the table below.

Name of doctor / dentist / pharmacy / hospital or provider	Treatment performed	Date of treatment	Amount charged (state currency)
e.g. doctor	e.g. surgery	e.g. DD/MM/YY	e.g. EUR 100

Declaration

I/we the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and agree that if I have made any false or fraudulent statement or there be any suppression or concealment, the policy shall be cancelled and the claim shall be forfeited.
I/we agree to provide additional information to the Company, if required.

Name	Signature	Date (DD/MM/YY)

Please review all details carefully before submitting. Completed forms can be submitted via email to submitclaim@bfm.bm

B. Cancellation

The following items must be included with this claim

1. **Copy of original itinerary**
2. **Terms and Conditions issued by Travel Agent and/or Transport, Tour or Accommodation Provider**
3. **Letter from Travel Agent or, where travel was not arranged through a Travel Agent, a letter from the relevant organization through whom travel was booked, confirming payments made, refunds given and any amounts you are out of pocket**
4. **Proof of payment for trip (e.g. Receipts, credit card/bank statements showing payments made)**
5. **If travel was cancelled due to Medical Reasons/Death – completed Medical Certificate (see last page of claim form) and copy of Death Certificate (if applicable)**

Failure to provide these documents may result in delays in processing your claim.

What was the reason you could not commence or complete your proposed journey	
Was your journey cancelled as a result of injury/sickness to yourself	☐ Yes ☐ No
Was your journey cancelled as a result of injury/sickness to any other person	☐ Yes ☐ No
If yes, please provide full name	
Relationship	Date of Birth (DD/MM/YY)
Address	
Nature of injury/sickness	
Date travel was booked (DD/MM/YY)	Date travel was cancelled (DD/MM/YY)

Details of journey

Date	Description of booking	Supplier	Amount paid	Refund received	Amount claimed
e.g. DD/MM/YY	e.g. plane ticket	e.g. Delta	e.g. $800	e.g. $300	e.g. $500

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C. Medical & emergency travel expenses

The following items must be included with this claim

1. Copy of your certificate of Insurance
2. Copy of original itinerary
3. Receipts, bank/credit card statements showing amounts paid by your for original Itinerary
4. Proof of payment for additional expenses claimed (e.g. tax invoices, receipts, credit card/bank statements showing payments made)
5. If the additional expenses were incurred due to the unfortunate event of a death – a copy of the Death Certificate

Failure to provide these documents may result in delays in processing your claim.

Please state the reason/event that caused the additional expenses being incurred
What was the unexpected expense incurred?

Please list each receipt/bill separately in the table below.

Date	Description of booking	Amount	Date of original plan	Description of original cost	Amount claimed
e.g. DD/MM/YY	e.g. hotel expense	e.g. currency	e.g. DD/MM/YY	e.g. flight	e.g. $500

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D. Personal property

The following items must be included with this claim

1. Copy of your certificate of Insurance
2. Proof of ownership of the items claimed (e.g. Duty, invoices, receipts, or credit card/bank statements proving purchase of the item/s)
3. Report made to the Transport Provider/Police/Hotel or other appropriate Authority
4. Any photos showing Proof of Ownership

Failure to provide these documents may result in delays in processing your claim.

Give full details of how losses, damage or theft occurred (detail each event)		
Date loss/damage occurred	Time ☐ am ☐ pm	Location/Country
Date loss/damage reported	Time ☐ am ☐ pm	Location/Country
Loss/damage reported to (police, airline or other authority) ☐ Yes ☐ No		
Were items lost/damaged by carrier ☐ Yes ☐ No	If yes, name the carrier	

Have you made a claim or complaint against any Carrier/Airline or other Authority or against any individual responsible for the loss or damage to your property? If YES, please provide details in the table below and attach copies of correspondence. If No, you should proceed to claim with your Carrier/Airline before submitting your claim

Are any of the other items covered by other insurance ☐ Yes ☐ No	If yes, which company
Policy number	Were all the missing items owned by you ☐ Yes ☐ No
If not, give details	

Details of articles claimed	Store where originally purchased	Date of purchase	Purchase price	Amount claimed	Proof of purchase attached?
e.g. ear buds	e.g. best buy	e.g. DD/MM/YY	e.g. $250 USD	e.g. $200 USD	
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No
					☐ Yes ☐ No

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E. Delayed luggage expenses claim

The following items must be included with this claim

1. **Copy of your certificate of Insurance**
2. **Itemised receipts for the purchase of Essential Items claimed by you**
3. **Property Delay. Report from the Carrier (e.g. bus line, airline, shipping line or rail authority) and confirmation of any compensation paid to you**
4. **Ticket and Baggage Tags from the Carrier who caused your luggage to be delayed**

Failure to provide these documents may result in delays in processing your claim.

Name of carrier who delayed your luggage	
Your arrival date (DD/MM/YY)	Your arrival time ☐ am ☐ pm
Date your luggage was returned to you (DD/MM/YY)	Time of return ☐ am ☐ pm
What compensation was received from the carrier	

Please complete the below schedule in full. Claims will be converted using the currency rate applicable at the date and time the expenses were incurred.

Description of essential items purchased	Date of purchase	Purchase price	Store purchased	Receipt attached
e.g. toothbrush	e.g. DD/MM/YY	e.g. $2.50 USD	e.g. Target	
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No
				☐ Yes ☐ No

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I/we agree to provide additional information to the Company, if required.

Name	Signature	Date (DD/MM/YY)

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Medical certificate

INSTRUCTIONS TO THE MEDICAL PROFESSIONAL: Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Travel Insurance claim. To be completed by the patient's usual Doctor/Dentist (at the claimant's expense) in all cases of cancellation and medical claims resulting from accident, sickness or death.

Name of person to whom the certificate applies		
Date of birth (DD/MM/YY)	Address	
Are you the patient's usual medical practitioner ☐ Yes ☐ No	If yes, for how long	If no, do you have access to their medical records ☐ Yes ☐ No

The claimant must indicate (by completing) which is applicable, either question 1 or 2

1. Alteration to/cancellation of travel arrangements prior to travel.

Did you recommend that travel be cancelled or postponed due to the patient's state of health	☐ Yes ☐ No
On what date did you give this recommendation (DD/MM/YY)	
Please give precise details of the nature of the sickness or injury which gave risk to this recommendation (including the final diagnosis)	
Did you fully explain the risk of traveling with this medical condition	☐ Yes ☐ No
On what date did the patient first become aware of their symptoms (DD/MM/YY)	
Please describe the symptoms described by the patient	
On what date were you first made aware of the condition, or change in condition (DD/MM/YY)	
Has the patient previously been investigated, diagnosed or treated in respect to the same/similar sickness or injury If Yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.	☐ Yes ☐ No
Did the patient make the travel arrangements against your advice (or the advice of another medical practitioner)	☐ Yes ☐ No

2. Treatment costs/additional expenses incurred during travel.

What do you understand to be the sickness or injury which resulted in the need to seek medical care/interrupt the patient's travel plans	
Has the patient previously been investigated, diagnosed or treated in respect to the same/similar sickness or injury	☐ Yes ☐ No
If Yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.	
Was there any indication that medical care may be required on the journey	☐ Yes ☐ No
Was the patient non-compliant with medical advice whilst on the journey	☐ Yes ☐ No
Did the patient travel against your advice (or the advice of another medical professional)	☐ Yes ☐ No

I certify that the statements contained in this Medical Certificate are true and correct.

Doctor's signature	Date (DD/MM/YY)	Doctor's stamp