CORPORATE TRAVEL INSURANCE (CTI) CLAIM FORM

IMPORTANT NOTE: Please answer all questions contained in this claim form as leaving items blank, using ticks, dashes and N/A may make it necessary for us to return your claim forms or lead us to ask more questions thus delaying the processing of your claim.

To enable us to process your claim, please return the duly completed claim form with supporting documents as listed in the subsequent section. We reserve the right to request additional information.

The acceptance of this Form is NOT an admission of liability on the part of Foyer Global Health S.A. Any documentary proof or report required by the Foyer Global Health S.A. shall be furnished at the expense of the Policyholder or Claimant.

Please note that the information you provide in this claim form will be used for the purposes of claims administration as outlined in this form and will not be used to update any of your existing records that our organization holds. If you wish us to update any of your information in our records, please contact our customer service representatives.

SECTION 1 - POLICYHOLDER

Name of the Policyholder			
Address			
Employer		Group Policy Number	

SECTION 2 - YOUR DETAILS

Full Name		Date of Birth	
Address			
Employee ID		Profession	
Work Phone		Mobile Phone	
Home Phone		Email Address	

SECTION 3 - BANK DETAILS

Bank Name		SWIFT Code	
Holder's Name		Currency	
IBAN Number			

SECTION 4 - TRAVEL INFORMATION AND AUTHORISATION

Travel Details

Proposed Travel Dates	From		To	
Actual Travel Dates	From		To	

Country or Countries to be visited					
Type of Travel? (Please select one or more)	Air ☐	Sea ☐	Rail ☐	Bus ☐	Car ☐
Reasons for Travel					

Travel Approval

This section must be completed by an Authorized Company Representative who can approve the above-listed travel.

Name (Last, First, M.I.)		Position	
I confirm that the above listed travel is authorized by my Company.			
Signature and Company stamp			

SECTION 5 – CLAIM FOR TRAVEL ACCIDENT (DEATH AND DISABILITY) OR OVERSEAS TRAVEL MEDICAL (INCLUDING DOMESTIC TRAVEL)

Does your claim arise from an accident or illness while you were travelling?	Accident ☐	Illness ☐
Date of accident, injury, or onset of illness:		
If illness - Type of illness, please describe:		
If injury - Give full details of accident, or injury occurrence and its cause (kindly specify the name /addresses of witnesses).		
Describe the treatment received:		
Name and address of treating Doctor / Hospital / Clinic:		
Date of treatment or treatments:		
Country / Countries where you were treated:		
Amount or amounts claimed (specify currency):		
Was the accident recorded by the police?	Yes ☐	No ☐
Police station / Public prosecution:		

Police Ref. No. / Prosecutors Ref. No.:		
Did the injured person consume alcohol, medication, or narcotics within the past 12 hours before or immediately after the accident?	Yes ☐	No ☐
If so, when?		
Blood sample	Yes ☐	No ☐
Result per mill:		

Important information: Please observe that false or incomplete statements made consciously (deliberately) will lead to the loss of insurance coverage. This shall also apply even if the insurer suffers no disadvantage from the situation.

SECTION 6 – CLAIM FOR TRAVEL DELAY / TRAVEL MISCONNECTION / FLIGHT OVERBOOKING / FLIGHT DIVERSION

Type of claim - Select one or more:	☐ Travel Delay ☐ Travel Misconnection ☐ Flight Overbooking ☐ Flight Diversion	
Original flight details:	Departure Date & Time: ☐ AM ☐ PM _ _ | _ _	Arrival Date & Time: ☐ AM ☐ PM _ _ | _ _
Actual flight details:	Departure Date & Time: ☐ AM ☐ PM _ _ | _ _	Arrival Date & Time: ☐ AM ☐ PM _ _ | _ _
Actual arrival of incoming connecting carrier from airport / ferry port, etc. (For travel misconnection only)		☐ AM ☐ PM _ _ | _ _
Length of delay (hours and minutes):		
Please state the reason provided by the tour operator, airline, cruise company, rail company etc for the cause of delay:		
Is there any compensation received or payable by the carrier?	Yes ☐	No ☐
If yes, please state the amount:		

SECTION 7 – CLAIM FOR PERSONAL LIABILITY

Bodily Injury – Provide relevant details – Name Address of injured Party and details of Injury (Use separate sheet in insufficient room):		
Damage to Property – List all Property Damage together with Name and Address or Party claiming damage against you. (Use separate sheet in insufficient room)		
Is the Injury or Damage related to a travelling companion?	Yes ☐	No ☐
Do you consider you were at fault?	Yes ☐	No ☐
If so, why?		

The following items must be included with this claim. (Photocopies can be submitted. If originals are submitted keep copies)

- Letter or document and all details of the claim made on you.

SECTION 8 - CLAIM FOR TRAVEL CANCELLATION, CURTAILMENT AND REPLACEMENT EMPLOYEES

Does your claim arise as a result of illness, injury or accident to yourself?	Yes ☐	No ☐
Does your claim arise as a result of illness, injury or accident to some other person or relative as defined in the policy? If yes:	Yes ☐	No ☐
Did you contact the Medical Cancellation Advisory Team?	Yes ☐	No ☐
If yes, then when?		
Name:	Address:	
Relationship:	Age:	
If your claim does not arise as a result of illness, injury or accident, describe the reason for your claim.		
Date you advised Travel Agency to cancel bookings:		
Has all or part of your travel been paid for? (If "All" got to 3 below)	All ☐	Part ☐
1. Amount of deposit paid:		Date Paid:
2. Balance of full fare not paid:		Date Paid:
3. Total cost of travel (Specify Currency):		
Value of forfeited portion of journey (if applicable):		
Refund received on cancellation:		
Full amount of booked travel being claimed:		
Were any alternative arrangements offered?	Yes ☐	No ☐
If yes, give details:		
Did you accept any alternative arrangement?		
Have you incurred any additional fares?		
Total amount being claimed (specify currency):		

Supporting documents for Section 8: The following items must be included with this claim. (Photocopies can be submitted. If originals are submitted keep copies)

1. Receipts and/or tickets relating to original, and any additional expenses incurred.

2. Proof of cause i.e., Original Doctor/Hospital certificate relating to injured or sick person or letter relating to cancellation, curtailment, or diversion of scheduled public transport, adoption of a minor child and significant property damage.

SECTION 9 – CLAIM FOR LUGGAGE LOSS OR DELAY / PERSONAL EFFECTS / ELECTRONIC EQUIPMENT / MONEY OR DOCUMENTS

Type of claim - Select one or more:	☐ Loss ☐ Delay ☐ Damage ☐ Theft	
Time of the event:	☐ AM ☐ PM _ _ | _ _	
Date of the event:		
Give full details of how the loss, delay, damage, or theft occurred (In case of loss, please give a breakup of business and private equipment's separately if possible):		
Was the event reported:	Yes ☐	No ☐
Time of the report:	☐ AM ☐ PM _ _ | _ _	
Date of the report:		
Were articles lost or damaged by the carrier?	Yes ☐	No ☐
If "Yes", name the carrier:		
If this is a luggage delay claim – Date and time when the items were returned to you:	Date of the return: Time of the return ☐ AM ☐ PM _ _ | _ _	
* Have you made a claim or complaint against any Carrier/Airline, Hotel or other authority or against any individual responsible for the loss or damage to your property? If so, attach details and copies of correspondence.	Yes ☐	No ☐
Note: The Warsaw/Montreal Convention imposes a liability upon the carrier, and you should claim on them first.		
Are any of the items covered by other insurance?	Yes ☐	No ☐
If "Yes", which insurer:		
Policy No.:		

Please attach a list of the claimed for items including the following information:

- Item description
- Name and address from where the items were purchased.
- Original date of Purchase
- Original Purchase Price (specify currency)
- Amount claimed (specify currency)

SECTION 10 – All OTHER CLAIMS

If you have any other claim, which does not fall within the sections stated above, please provide details here:	

SECTION 11 – PATIENT'S DECLARATION AND CONSENT

I hereby certify that to the best of my knowledge this claim form does not contain any false, misleading or incomplete information. I understand and accept that in the event this claim is found to be fraudulent in whole or in part, the policy will be rendered null, and void and I will be liable for legal action. In respect of any medical claim, I hereby authorise my general practitioner, health professional or other relevant medical provider to provide any health details or medical records that may be requested by Foyer Global Health S.A. or their appointed representatives. If the patient was a minor, a parent or guardian should sign this section.
Data Protection:

You can find all the information about the processing of your personal data on the privacy policy of Foyer Global Health S.A. available on the website (Privacy policy of our insurance company).

Patient's Signature	Date

Get in touch with us

Please feel free to contact us in case of any questions on our General Terms and Conditions of Insurance or products:

Lines are open
Monday to Friday: 8am to 5pm (CET)

Phone: +352 270 444 3500

Or contact us anytime at:
policy@globalhealth.insurance

Foyer Global Health S.A.
12, rue Léon Laval
L-3372 Leudelange
Luxembourg

Web: globalhealth.insurance
R.C.S. Luxembourg B 134.471

CTI CLAIM FORM 10.24