

**Your Student Travel Insurance Claim Form**

For Studentguard and Studentguard+ Policies

THANK YOU FOR NOTIFYING US OF YOUR CLAIM. PLEASE COMPLETE ALL QUESTIONS.
IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE ‘N/A’.

PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS FORM

|  |  |
| --- | --- |
| Name of Policyholder (school/college in the UK/Eire):  | **Melton College** |
| Policy No.: | **ORT/GPAIBT/10629792** |

|  |  |
| --- | --- |
| Full name of Insured Person (Mr, Mrs, Miss, Ms): | Full Name |
| Date of birth: | DOB. |
| Full Address: | Full Address. |
| Postcode: | Post Code |
| Telephone No. (Business): | Tel No. |
| Telephone No. (Home): | Tel No. |
| E-mail address (this will be used to contact you regarding your claim): | Email |

DETAILS OF EXPENSE- All accounts, bills, receipts, medical certificates, booking invoices, any correspondence, and any other documents relative to this claim should be forwarded to Ortus Travel Claims:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Insured Person | Nature of expense | Name and address of doctor or hospital attended | Currency being claimed | Amount | Paid |
| Name | Click to add text | Hospital | Currency | Amount | Paid |
| Name | Click to add text | Hospital | Currency | Amount | Paid |
| Name | Click to add text | Hospital | Currency | Amount | Paid |
| Name | Click to add text | Hospital | Currency | Amount | Paid |
| Name | Click to add text | Hospital | Currency | Amount | Paid |
|  | TOTAL: £ | Total |

MEDICAL EXPENSES- accident/sickness details. Please provide a copy of your original itinerary/travel documents if available:

|  |  |
| --- | --- |
| Date of trip: | Date |
| Please give exact date and place when injured or taken ill:  | DATE: | Date | PLACE: | Location |
| If accident, please state fully: Click or tap here to enter text. |
| (a) Where the accident took place:  |
| Click or tap here to enter text. |
| (b) How the accident occurred:  |
| Click or tap here to enter text. |
| (c) The injuries sustained:  |
| Click or tap here to enter text. |

MEDICAL EXPENSES - accident/sickness details *Continued*

|  |
| --- |
| If illness, please state full details of illness:  |
| Click or tap here to enter text. |
| Have you (the Insured Person) ever suffered from this illness before? YES [ ]  / NO [ ]  |
| If YES, please give details with relevant dates: | Date |
| PLEASE ALSO PROVIDE A LETTER FROM YOUR DOCTOR TO SAY THAT YOU (THE INSURED PERSON) WERE FIT TO TRAVEL. |
| Please state whether you (the Insured Person) were in hospital: YES [ ]  / NO [ ]  |
| If YES, please state dates of hospitalisation: Admitted:  | Date | Discharged: Date |  |
| Have you (the Insured Person) previously claimed under this or a similar policy? YES [ ]  / NO [ ]  |
| If YES, please give details:  |
| Click or tap here to enter text. |
| Are you (the Insured Person) covered under any group private medical scheme i.e. BUPA/PPP or any similar scheme? YES [ ]  / NO [ ]  |
| If YES, please give name, address and reference number of the company concerned:  |
| Name.Address |
| Please give name and address of General Practitioner in the UK:Name |
| Address |

CANCELLATION / CURTAILMENT - Travel Details

|  |
| --- |
| Please give the reason for the Cancellation/Curtailment of the journey: |
| Click or tap here to enter text. |
| Please state the scheduled times of travel: Time of Travel |
| Outward date: | Date | Return date: | Date | Date Journey Booked: | Date. |
| Date of Cancellation/Curtailment: Date. |
| PLEASE PROVIDE A COPY OF YOUR FLIGHT DETAILS INCLUDING ANY TRANSFERS, ACCOMMODATION AND COURSE BOOKING DOCUMENTS.  |
| If the Cancellation/Curtailment was due to illness or injury, please state: |
| (a) The name and age of sick/injured person: | Name. Age |
| (b) The exact nature of illness/injury and the commencement date: |
| Click or tap here to enter text. |
|  |
| Has the person concerned previously suffered the same or a similar complaint? YES [ ]  / NO [ ]  |
| If YES, please give details with relevant dates:Click or tap here to enter text. |
| PLEASE PROVIDE MEDICAL EVIDENCE FROM THE ATTENDING DOCTOR OR PLEASE ASK THE ATTENDING DOCTOR TO COMPLETE THE FOLLOWING: - |
| Nature of complaint preventing travel: | Click or tap here to enter text. |
| Date of treatment first sought: | Date | Validation Stamp |
| Was the cancellation of the journey medically necessary? YES [ ]  / NO [ ]  |
|  |
| Signed: Signature | Date: Date |
| If journey was cancelled please give details of expenditure incurred: |
| Total amount paid: | Paid | Total amount refunded: | Refunded | Amount to be claimed: | To be Claimed |
| PLEASE PROVIDE A CANCELLATION INVOICE TOGETHER WITH TRAVEL DOCUMENTS FROM THE TOUR OPERATOR, TRANSPORT CARRIER OR ACCOMMODATION AGENT. |

If journey was curtailed,please provide details of additional travel and sundry expenses including how these were incurred. Receipts need to be enclosed for these charges.

PERSONAL INJURY DETAILS

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Please give exact date and time when injured:  | Date: | Date. | Time: | Time | am [ ]  / pm [ ]  |
| Please state fully: |
| (a) Where the accident occurred: |
| Click or tap here to enter text. |
| (b) How the accident occurred: |
| Click or tap here to enter text. |
| (c) The injuries sustained: |
| Click or tap here to enter text. |
| Have you (the Insured Person) previously claimed under this or a similar policy? YES [ ]  / NO [ ]  |
| If YES, please give details: |
| Click or tap here to enter text. |
| Please give the name and address and policy number of any other insurance that may cover this injury: |
| NameTel No.Tel No.Tel No. |

COURSE FEES & ACCOMMODATION - If you are claiming for your course fees or accommodation costs please ask your school to complete this section of the form.

 We confirm that the above student has booked and paid for the following courses, accommodation and/or excursions.

|  |  |  |  |
| --- | --- | --- | --- |
| Date of arrival: | Date | To: | Name |
| Please provide full breakdown of all costs paid: |
| 1. | Click or tap here to enter text. |
| 2. | Click or tap here to enter text. |
| 3. | Click or tap here to enter text. |
| 4. | Click or tap here to enter text. |
| Is the student entitled to a refund under your booking terms & conditions? YES [ ]  / NO [ ]  |
| If YES, please provide a full breakdown of the refund due:Official Stamp of School |
| 1. | Click or tap here to enter text. | OFFICIAL STAMP OF SCHOOL |
| 2. | Click or tap here to enter text. |
| 3. | Click or tap here to enter text. |
| 4. | Click or tap here to enter text. |
|  |
| Signature of SchoolSignature |  |
| Please note that any refund due to you from the school will be paid by them and not this insurance. |  |

PERSONAL BELONGINGS AND MONEY - Travel Details

|  |  |
| --- | --- |
| Please give date of loss/damage/theft: | Date. |
| In which country did the loss/damage/theft occur? | Country |
| Please give full details of the loss/damage/theft: |
| Click or tap here to enter text. |
| To whom was the loss/damage/theft reported?  | Click or tap here to enter text. | Please provide a copy of this report |
| NOTES: |
| 1. All losses should be reported to the local police and a report obtained. This should be forwarded to Ortus Travel Claims. |
| 2. All losses or damaged property which occurred whilst in the custody of an airline should be reported and a Property Irregularity Report Form obtained. This should be forwarded to Ortus Travel Claims together with the ticket stubs. |
| On which date was the loss/damage/theft reported? | Date |
| If article(s) lost/stolen: |
| What steps were taken regarding recovery of the article(s)? Please provide any written evidence. |
| Click or tap here to enter text. |
| If article(s) damaged: |
| Please supply estimates for cost of repairs or a letter from an appropriate dealer confirming irreparably damaged. |  |
| Please supply receipts - if not available please supply replacement estimates/invoices. |
| Is any property lost/damaged/stolen insured by any other company? YES [ ]  / NO [ ]  |
| If YES, please supply name, address, telephone number and policy number: |
| NameTel No.Tel No.Tel No. |
| Please supply name, address, telephone number and policy number of household contents insurers: |
| NameTel No.AddressPolicy No. |
| Have you had any previous claims on this type of insurance? YES [ ]  / NO [ ]  |
| If YES, please give details with relevant dates: |
| Date- Details |
| Date- Details |
| Date.- Details |
| Please ensure the ‘Particulars of Claim’ section overleaf is fully completed. |

PARTICULARS OF CLAIM

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| Full description of each items of property lost, damaged or stolen | State to whom property belonged | Date of purchase | Original cost price | Amount deducted | Amount claimed | Receipts/replacement estimates attached |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| Description of items | Owner of property. | Date Purchased. | Original Cost | Amount deducted | Amount Claimed |  YES [ ]  / NO [ ]  |
| TOTAL SUM CLAIMED | Total Claimed |  |

PLEASE ENSURE YOU PROVIDE RECEIPTS IF POSSIBLE OR REPLACEMENT ESTIMATES FOR ITEMS £100 OR OVER.

DOCTOR’S STATEMENT - This section must be fully completed by attending doctor. You (the Insured Person) are responsible for any fee to complete this section.

|  |  |
| --- | --- |
| Patient’s name (Mr, Mrs, Miss, Ms): | Name |
| Date of birth: | Date | Height: | Height. | Weight: | Weight |
| Please give full details of injury: |
| Click or tap here to enter text. |
| Final diagnosis: |
| Click or tap here to enter text. |
| When did the patient first receive medical attention for this condition? | Click or tap to enter a date. |
| Has the patient ever suffered with this or any similar condition before the present episode? YES [ ]  / NO [ ]  |
| If YES, please give details including dates, treatment and consultation: |
| Click or tap here to enter text. |
| Are you the patient’s usual doctor? YES [ ]  / NO [ ]  |
| If NO, please give name and address of usual doctor: |
| NameAddress |
| On what date did incapacity commence? | Date |
| Is the patient still incapacitated? YES [ ]  / NO [ ]  |
| If YES, when will the patient be able to return to their studies? | Click or tap here to enter text. |
| If NO, when did incapacity cease? | Date |
| Was the patient hospitalised as a result of this condition? YES [ ]  / NO [ ]  |
| Is there any additional information that you feel is relevant? |
| Click or tap here to enter text. |
| Signed: | Signature | Date: | Date | Qualifications: | Qualifications |
| Please use Validation Stamp or complete in BLOCK CAPITALS: |
| Name:Doctors Stamp | Name |  |  |  |
| Address: |  |  |
| Address Line 1 |  |  |
| Address Line 2 |
| Address Line 3 |
| Address Line 4 |
| Postcode: | Post Code |
| Telephone No. | Tel No. |

Thank you for your assistance in completing this form

ACCESS TO MEDICAL REPORTS ACT 1988- Before your attending doctor can give a medical report on this claim form, which is a requirement of this claim, you must give your consent. Before giving your consent, you should also be aware of your rights under the Act which are summarised as follows:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the doctor to amend any part of the report which you consider to be incorrect or misleading. If the doctor does not agree with your request, you
may attach your comments to the report.

NB: The doctor may withhold all or part of the report from you if he/she considers that you may be physically or mentally harmed by it.

PATIENT DECLARATION - Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim:

1. I hereby consent to Ortus Travel Claims seeking medical information from any doctor who at any time has attended me (the Insured Person) concerning conditions which
affect my physical or mental health.
2. [ ]  I DO wish to see the report before it is sent to Ortus Travel Claims.
3. [ ]  I DO NOT wish to see the report before it is sent to Ortus Travel Claims.
4. I authorise such doctor to disclose such information to Ortus Travel Claims.
5. I agree that a copy of this consent shall have the validity of the original.

Signed: Date:Date



Signature

(Please sign this if you are aged 18 years or more. If you are aged under 18 years this must be signed by your parent/legal guardian or an authorised person at
your school/college, on your behalf.)

BANK DETAILS- When the claim has been approved you may have the payment credited direct to your bank account. This payment method is both speedier and safer than by cheque. If you would like to take advantage of this arrangement, please complete the following:

|  |
| --- |
| Name and address of your bank/building society: |
| Name | Currency required, if other than £ Sterling: | Currency |
| Address Line 1 | Account Name: | Name |
| Address Line 2 | Account Number: | \* | \* | \* | \* | \* | \* | \* | \* |  |
| Address Line 3 | Branch Sort Code: | \* | \* | / | \* | \* | / | \* | \* |
| Postcode: | Post Code | IBAN Number | IBAN Number |
| If payment has already been made on your behalf, please give details to whom this claim payment should be made: | Swift/BIC code | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* | \* |  |
| Name: | Name |
| Address: | Address | Postcode:Post Code. |  |

DATA PROTECTION

In order to administer your claim Canopius Managing Agents Limited and One Education will use personal information which you supply for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy.

To view the Privacy Policy Canopius Managing Agents Limited please see: [www.canopius.com/privacy](http://www.canopius.com/privacy). The One Education privacy policy is available here: https://www.onebroker.co.uk/privacy.html

Canopius Managing Agents Limited registered in England & Wales number 01514453 with registered office at Floor 29, 22 Bishopsgate, London, United Kingdom, EC2N 4BQ. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority. Reference No 204847. Full details can be found online at register.fca.org.uk.

DECLARATION - I declare that all the information given is to the best of my knowledge and belief, full true and correct.

Signed: Date:Date.



Signature

(Please sign this if you are aged 18 years or more. If you are aged under 18 years this must be signed by your parent/legal guardian or an authorised person at your school/college,
on your behalf.)

CHECKLIST - Please ensure you have:

[ ]  completed ALL relevant questions on this claim form

[ ]  enclosed all requested information and documentation

[ ]  signed this claim form

 AS FAILURE TO DO SO WILL RESULT IN A DELAY IN HANDLING YOUR CLAIM**.**Please return the completed claim form together with any enclosures to:

Tel: +44(0)800 193 3326 (Mon-Fri 9am-5pm)

Email: ah-claims@ortusunderwriting.com

If you require Medical Assistance please contact

Ortus Assistance: +44(0)800 193 0092 (24 hour)

SG181204

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