U M Association Limited

UMAL

# Medical Expenses Claim Form

Thank you for notifying us of your claim
Please complete all questions – if any question is not applicable please state 'N/A'

This form can be completed electronically or by hand. Please send the completed form together with all relevant correspondence to: **U M Association Ltd, 5 St Helen's Place, London EC3A 6AB**
**Telephone: 020 7847 8670 Fax: 020 7847 8689 Email: claims@umal.co.uk**

Please note: Windows 10 users viewing this form in MS Edge or Mac Users viewing in Preview may encounter problems saving the information entered. To avoid this, please ensure you have downloaded this form and are viewing it in the latest version of Acrobat Reader.

Name of Institution (University, College etc)

Certificate no.

Date on which travel commenced

Date on which travel due to end

Full name of person covered (Mr, Mrs, Miss, Ms)

Date of Birth

Full address including postcode

Telephone no.

Email

| | Full name of other persons covered | Date of Birth | Relationship |
|---|---|---|---|
| 1 | | | |
| 2 | | | |
| 3 | | | |

**Please ensure you sign the declaration on the last page of this claim form**

## Accident/Sickness Details

Type of travel: Business ☐ Holiday ☐ Placement ☐ Internship ☐

Please give exact date and place when injured or taken ill

Date ☐ Place ☐

Country in which incident occurred ☐

**If accident**, please state fully:

a) Where the accident occurred

b) How the accident occurred

c) The injuries sustained

**If illness**, please state full details of the illness:

Has the person covered ever suffered from this illness before? YES ☐ NO ☐

If 'YES', please give details with relevant dates

Please state whether the person covered was in hospital YES ☐ NO ☐

If 'YES', please state dates of hospitalisation: Admitted ☐ Discharged ☐

Has the person covered previously claimed under this or a similar policy? YES ☐ NO ☐

If 'YES', please give details

Is the person covered 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

Did the person covered use a European Health Insurance Card
(if treated within the EU)? YES ☐ NO ☐

## 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 the company**

| Claimant name | Nature of expense | Name and address of doctor or hospital attended | Currency of expense | Amount £ | Paid ✓ |
|---|---|---|---|---|---|
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**Total £**

**Please ensure you provide original receipts/invoices for all expenditure**

## Declaration

This form can be signed using a Digital Signature. Instructions are provided in the signature box below. For further information please click here (https://helpx.adobe.com/acrobat/using/certificate-based-signatures.html).
If you prefer, the form can be signed by hand, scanned and emailed or posted to us.

| Name | Signature |
|---|---|
| Position | |
| Date | |

Please ensure:

- You have completed ALL relevant questions on this claim form.
- You have enclosed ALL requested information/documentation.
- You have signed this claim form.

As failure to do so will result in delay in handling your claim.

Thank you for fully completing this form.