Emergency Overseas Claim Form
In-patient/out-patient expenses

laya healthcare
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Using this claim form

This claim form has been designed to help you make a claim for treatment received in the case of an accident, injury or emergency while travelling abroad (or while overseas or for overseas medical expenses).

Before submitting your claim

Check the member's section is fully completed.

- Check the medical section is fully completed.
- Check all relevant sections have been signed - both by the **laya healthcare** member and the patient's Consultant. Check that the original accounts are attached.
- If you require copies of accounts please let us know when you submit your claim.

Important

Please note that out-patient receipts will not be returned following assessment of your claim. Please retain copies of your receipts prior to submission, if you require these.

The Revenue Commissioners will now accept your statement of claim (which we will send to you) as evidence of medical expenses incurred, therefore you do not need your medical receipts returned.

In order to make a claim

Please answer all the questions below, complete the relevant sections, read and sign the declaration and consent section. You should send your claims to us as soon as possible. We will only review this claim if received within 6 months of the emergency overseas illness/injury treatment date.

Further information

For benefits and claim queries, please contact us on **1890 700 890** or **021 202 2000** or visit **www.layahealthcare.ie**

Claims should be sent to: laya healthcare, PO Box 12679, Dublin 15.

1 Member's details

Membership no: ☐☐☐☐☐☐☐☐☐☐

Title:	Surname:	Forenames:
Date of birth: Day ☐☐ Month ☐☐ Year ☐☐		Telephone:
Correspondence address:		
Email:		
Laya healthcare scheme (please insert your scheme name here):		

2 Address of person to whom correspondence should be sent:

Address:	
Email:	
Name of person to whom claim payments should be paid:	

3 Trip details

Departure date:	Country visited:
Return date:	Travel agent name:
Total number of days:	Travel agent telephone number:

4 Previous claims

Has the claimant(s) previously made a claim under any travel insurance policy or previously claimed from their private health insurance for overseas emergency treatment? Yes ☐ No ☐ If "Yes" please give details below:

Insurance Company:	Date of claim:
Amount of claim:	Type of claim:

5 Declaration and consent

The information I/We have given is true. If any of the information I/We have given or any of the information given on my/our behalf is incorrect, I/We understand that you will be able to take away my/our rights under this policy. I/We understand and give explicit consent that the information I/We provide, including any sensitive information such as my/our health records will be passed to or used by **laya healthcare**/your insurers for my/our insurance. I/We understand that **laya healthcare** will retain a computerised record of this claim and that they may release certain information pertaining to this claim to other insurers or other interested parties involved with this claim. **Laya healthcare** maintains all data in accordance with the **Data Protection Act**.
I/We declare that **laya healthcare** may contact my travel insurance company in order to ensure that any monies payable from a Dual insurance company as a result of emergency overseas treatment may be repayable to **laya healthcare**.

✗ **Policyholder's signature** (a parent or guardian if patient is under 16)	**Date**

Note: Payment and Explanation of Benefits will be issued to the policyholder.

Data Protection Statement

The information you provide will be used to manage the administration of your policy and is held in accordance with the **Data Protection Acts** 1988 and 2003 (as amended). We may need to collect sensitive information (such as medical information) about you and others named on the insurance policy. By providing this information you will be agreeing to us or our agents or other insurers processing that information for the purpose outlined above. In the event that your treatment has involved another person, or if their details are likely to be documented in your Medical Notes/File, then their express consent should be acquired in advance of sharing sensitive data. Medical information will be kept confidential and may be disclosed, on a strictly confidential basis to those involved with your treatment or care or their health professional agents. Information may also be shared with other insurers, either directly or through people acting for the insurer such as Investigators and where we are entitled to do so under the **Data Protection Acts**. However, anonymised data – that is, information which does not identify an individual – may be used by **laya healthcare**, or disclosed to others, for research or statistical purposes. Access to non-medical information may be granted by **laya healthcare** to others on a strictly confidential basis in the course of and for the purpose of the efficient administration of **laya healthcare** (for example in connection with audit, systems development, managing and improving our services). You have a right to apply for a copy of the information held by us about you (for which a small charge, not exceeding €6.35, may apply) and you have a right to have any inaccuracies in your information corrected. Please send your request in writing to the Information Protection Manager, at **laya healthcare**, Eastgate Road, Eastgate Business Park, Little Island, Co Cork.

6 Name of the person who suffered from the illness/injury

7 Third party section

Is the treatment required following an accident/injury? Yes ☐ No ☐ If "Yes" please give details:

Are you taking a legal case against anyone in relation to this claim? Yes ☐ No ☐ If "Yes" please provide solicitors details:

8 Date of the onset of illness/Injury

Day: ☐☐ Month ☐☐ Year ☐☐

9 Was the person suffering from the illness/injury aware of this condition prior to travelling overseas

Yes ☐ No ☐

If "Yes" please give details:

10 Brief description of the emergency illness/injury

Please give details:

11 Details of the hospitalisation or in-patient treatment.

Were you hospitalised or kept in as an in-patient? Yes ☐ No ☐

Did you contact the **laya healthcare** emergency overseas assistance company? Yes ☐ No ☐

If "Yes" what was the date of the first call to the 24 hour medical emergency service:

If "Yes" quote reference number received from the 24 hour medical emergency service:

Date and time admitted to hospital Date: Time:

Date and time discharged from hospital Date: Time:

Total number of days as an in-patient in hospital:

12 Travel insurance details

Did you take out alternative travel insurance for your trip? Yes ☐ No ☐

If "Yes", please advise

Insurers name: Schedule number:

Address:

Policy type:	Annual ☐ Shortstay ☐
Issue date of policy:	Excess waiver: Yes ☐ No ☐

13 Documents you need to send to **Laya Healthcare** (send original documents)

- Original booking invoice/travel tickets
- Confirmation from the treating doctor of hospitalisation and/or treatment (if applicable)
- Original receipts/invoices for medical expenses incurred. (Please keep a copy of all receipts)
- For trips to Europe, E111 card number, for trips to Australia, copy of Medicare form.

14 In the table below please detail all medical expenses which you incurred and for which you are claiming:

Date expense incurred:

Description of expense:

Name of provider: (i.e. Hospital/Clinic/Treating Doctor)

Non euro currency amount:

Euro currency amount:

Have you paid for the expense: Yes ☐ No ☐

Total amount claimed in euros:

Exchange rate used to convert non-euro currency to euros: