

Branch/Broker/TII:

Policy No:

Please return this form together with respective documents (invoices/receipts/quotations) to: GasanMamo Insurance, Msida Road, Gżira, GZR 1405, Malta. For any queries please call on 2134 5123 ext 5

INSURED'S DETAILS

Name & Surname of claimant:

Address:

ID No:

Tel No/Mob No:

Occupation:

Name of Employer:

Email:

GENERAL SECTION

Do you have any other policies in force with GasanMamo Insurance Ltd?

Yes

No

If yes, please give details.

Departure Date:

Arrival Date:

Is there any other insurance in force (e.g. Homeholders/Personal Accident/All Risks/ Travel/ Credit Card/Gold/Premier/ Platinum Account Holders etc) which also covers this loss/expense?

Yes

No

If yes, please give details below.

Insurance Company:

Policy No:

Type of Policy:

GENERAL SECTION - CONTINUED

Have you ever claimed under a travel policy before? Yes No

If yes, please give details.

Total length of holiday:

Countries Visited:

Purpose of Journey:

Please choose applicable section.

MEDICAL EXPENSES (ATTACH MEDICAL CERTIFICATES & INVOICES)

Nature of Injury or Illness:

Duration of Injury of Illness: *From* / / *to* / /

Briefly describe the circumstances of the injury or illness.

If illness, have you ever suffered from this illness previously? Yes No

If yes, please give details including dates.

Did you require consultation or treatment during the past 12 months relating to this illness/injury?

Did you know about your illness prior to your departure from Malta?

Did you require the assistance of the Emergency Medical Service? Yes No

If yes, please give details.

MEDICAL EXPENSES - CONTINUED

Please give details and nature of medical and other expenses incurred.

Description	Amount being claimed in €
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<hr/>	<hr/>
<hr/>	<hr/>
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<hr/>	<hr/>

Do you require any further treatment in Malta related to your injury/illness? Yes No

If yes, please give details.

Please specify details of any private Health Insurance which covers you for the above expenses.

Insurance Company:

Policy No:

Did you make use of your European Health Insurance card on your admission to hospital? Yes No

CANCELLATION & CURTAILMENT (ATTACH MEDICAL CERTIFICATES & INVOICES IF APPLICABLE)

Please state reason for cancellation or curtailment of holiday.

Date of event leading to the cancellation or curtailment: / /

If caused by illness, have you suffered from this before? If so, please give details.

Have any deposits been recovered? Yes No

If yes, please state amount. If No, what steps have been taken to obtain recovery of deposits?

CANCELLATION & CURTAILMENT - CONTINUED

Amount being claimed (Attach Invoices): €

Number of persons claiming:

HOSPITAL BENEFIT

Were you admitted to hospital as an in-patient as a result of accident or illness?

Yes

No

Date & Time admitted to hospital: / / : am/pm

Date & Time discharged from hospital: / / : am/pm

Please attach letter from hospital confirming dates and times of both admittance and discharge

Did you make use of your European Health Insurance card on your admission to hospital?

Yes

No

DIRECT CREDIT DETAILS

Kindly complete your bank details below if you would like to receive payment of your claim directly into your bank account. We can only make SEPA payment.

Account holder details

Name:

ID No:

Address:

Town:

Mob No:

Email:

Bank account details

Name of Bank:

Country:

IBAN No:

DATA PROTECTION NOTICE

To the extent that the information supplied by you, whether orally or in writing, constitutes personal data, including sensitive data within the provisions of the Data Protection Act, you consent to the processing of such data for purposes of administering your proposal for insurance, your Policy, underwriting, handling of claims and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics. We may be required to collect further information from our sub-agents, other insurance companies, insurance intermediaries or insurance associations.

In addition, we may pass some or all of the information to other insurance companies, or insurance associations for underwriting and claims handling purposes and also for the purposes of detecting, preventing and suppressing fraud and of keeping statistics. This also helps us to check the information provided. When we deal with your request for insurance, we may search this information. When you tell us about an incident which may or may not give rise to a claim, we will pass information relating to it to the Malta Insurance Association.

We and other companies within our group would like, on occasion, to keep you informed of our products and services, by mail, fax, e-mail or other electronic means. Please inform us in writing if you do not wish to receive this information or if you wish to receive such information solely from GasanMamo Insurance Ltd. Moreover, we hereby ask you whether you wish to receive direct marketing information from us by e-mail to your e-mail address provided above.

You have the right to request access to, and rectification of, your personal data held by us by directing your request in writing signed by yourself to the Data Protection Officer, GasanMamo Insurance Ltd, Msida Road, Gzira GZR 1405.

DECLARATION

I/We declare that the statements made are true to the best of my/our knowledge and belief and fully agree with the above and hereby consent to the above treatment of my personal data.

Date:

Full name in block letters:

Signature of policyholder: