H Savy Insurance Co Ltd

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Medical & Repatriation / Evacuation Expenses

Claim form

By lodging your claim with H Savy Insurance Limited, you hereby declare that the statements, facts and information herein contained are true and correct to your knowledge and or belief. That the statements, facts and information herein provided by you are complete and accurate. Failure to faithfully make full disclosure of the facts and information you know or ought to know may render you claim null and policy void.

Note: (1) The issue of this form does not imply admission of liability on the part of the Company.
(2) The INSURED is requested to answer all questions fully and return without delay.

Please use BLOCK CAPITALS and tick where appropriate

Insured

Title (Mr, Mrs, Miss, etc):	Surname:	Maiden Name:
Name:		
Address:	Email Address:	
(a) Trade or Business:	Telephone No:	
(b) Policy No:	Class of insurance:	
Period of Insurance: From	To	

Details of Patient

Name of Patient:
Address of Patient:
Date of Birth:

Details of Incident

Date:	Time: (a.m. or p.m.)		
Place:			
If hospitalised, please give dates and times of:	Admission		
	Discharge		

Brief details of how the accident happened:

Costs you have already paid

Please include all receipts in relation to the costs you are claiming below

Nature of Expense	Who did you pay?	Foreign Amount	Currency Exchange	Seychelles Rupees Amount
			Total Amount Claimed	

Outstanding Bills

Please provide details of any unpaid bills or of any further bills you anticipate but may not yet have received.

Nature of Expense	Name of Firm / Hospital etc.	Known / Anticipated Amount
	Total Due	

Name & Address of General Practitioner:	

Patient Declaration

I/We confirm the facts stated on this form to be true and accurate to the best of my/our knowledge.

I/We give authority to the insurers or their representatives to contact my/our/the patient's medical practitioners for any additional information required in connection with this claim. I have been informed of my rights regarding medical reports and agree that a copy of this consent shall have the validity of the original. I/We understand that the information provided in relation to this claim may be shared with other insurers for the purpose of dealing with this claim and eliminating insurance fraud.

I do/do not* wish to see any medical report before it is sent to my insurers (*delete as applicable).

Date: ..... Signature of Insured: .....