

CLAIMS FORM

Please return the completed Claim Form, supporting documentation and a copy of your Certificate of Insurance to: Kinsure Claims Department, LAMP Services Limited, Chester House, Harlands Road, Haywards Heath, West Sussex, RH16 1LR +44 1444 444 951 Fax + (44) 1444 450872

Policy Number

Lead Policyholder Name

Claim Details

(a) Claim Reference Number

(b) Relative's name

(c) Date of Birth

(d) Relative's Relationship (e.g. Mother, Father, Brother)

(e) Details of accident or illness, please give an overview (if relative has passed away please go straight to section (f)):

Date of accident/onset of illness:

Details (please attach an additional sheet of paper if more space required):

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(f) If Relative has passed away, please give the following details:

Date

Time

Country

Location/Address

(g) Details of expenses claimed (*valid receipts are required*):

Nature of Expense <i>(flight, taxi, etc)</i>	Provider <i>(BA, Emirates, etc)</i>	Currency <i>(GBP, AUD, etc)</i>	Payment Method <i>(credit card, Cash etc)</i>	Date of Service
Total Amount Claimed:				

(h) Declaration

I declare the above statements are true and accurate to the best of my knowledge and belief. I have not withheld any information within my knowledge connected with this claim. I agree to provide the insurer with any further information as may be reasonably required. I understand that the insurer does not admit liability by issue of this form. I give authority to the insurer or their representative to contact my Medical practitioners for any information required in connection with this claim.

Policyholder Signature

Date