BF&M

Travel Claim Form

Use of this form is not to be taken as an admission of liability.

Please complete this form and sign. Failure to disclose all material information and/or misrepresentation could result in your insurance being declared void by the insurer and a claim being rejected. When complete, please send this form via email to submitclaim@bfm.bm, or fax it to 295-8647.

1. Claimant details (all fields are mandatory)

Policyholder name (first/middle/last):	DOB (dd-mmm-yyyy):
Claimant name (first/middle/last):	Policy number:
Address:	
Phone: H W C	Email:
Travel agent name (if used):	Departure booking travel arrangements (dd-mmm-yyyy):
Departure date (dd-mmm-yyyy):	Return date (dd-mmm-yyyy):

Local bank information (complete for payment to banks in Bermuda)

The bank account name MUST include the name of the policy owner (single or joint account). Payment will be less any applicable excess.

Account name:

☐ HSBC account number:

☐ BNTB account number:

☐ Clarien account number:

2. Travel arrangements

Did you use a credit card to purchase your travel (e.g. flights, accommodation, tours)? ☐ Yes ☐ No

If yes, name on credit card:	Financial institution name:

Card type: ☐ Visa ☐ Mastercard ☐ Amex ☐ Other:

3. Claim information

Please tick all the applicable box(s) relating to your claim type and answer the appropriate section.

- ☐ A. Personal accident (Please complete pages 1, 2, 3, 11 and 12)
- ☐ B. Cancellation (Please complete pages 1, 4 and 5)
- ☐ C. Medical and emergency travel expenses (Please complete pages 1, 6, and 7)
- ☐ D. Personal property (Please complete pages 1, 7 and 8)
- ☐ E. Delayed luggage expenses claim (Please complete pages 1 and 9)

A. Personal accident

The following items must be included with this claim:

1. Copy of your Certificate of Insurance
2. Medical/Hospital/Dental Report detailing Treatment and Diagnosis
3. Itemised accounts giving a breakdown and description of costs claimed, together with receipts if any accounts have been paid by you
4. Completed Medical Certificate

Failure to provide these documents may result in delays in processing your claim.

Type of injury or sickness:	Date of accident/sickness (dd-mmm-yyyy):
If injury, give full details of accident:	
Date of first medical consultation (dd-mmm-yyyy):	Doctor, dentist or hospital name:
Details of other treatment by doctor, dentist or hospital:	
Hospital admitted date (dd-mmm-yyyy):	Hospital discharge date (dd-mmm-yyyy):
Have you ever suffered from the same or similar injury or sickness in the past? ☐ Yes ☐ No If yes, give details including dates, names and addresses of treating physicians:	
Health insurer name:	Family doctor name:

Please list each receipt/bill separately in the table below

Date of treatment (dd-mmm-yyyy)	**Doctor/dentist/pharmacy/hospital or provider name** (e.g. doctor)	**Treatment performed** (e.g. surgery)	**Currency** (e.g. USD, KYD, EUR)	**Amount** (e.g. $500)
			Total amount:	

Declaration

I/we the above named, do hereby, to the best of my/our knowledge and belief, warrant the truth of the foregoing statements in every respect and agree that if I have made any false or fraudulent statement or there be any suppression or concealment, the policy shall be cancelled and the claim shall be forfeited.

I/we agree to provide additional information to the Company, if required.

Declaration (cont'd)

Data protection declaration

By signing this form, I confirm/understand that:

- *I consent to BF&M processing my personal data, and that of any minor, including health and medical data, in accordance with BF&M's Privacy Policy (www.bfm.bm/privacy) and the short form notice overleaf.*
- *I understand that I may withdraw my consent at any time by email to privacy@bfm.bm but that may impact BF&M's ability to provide insurance or related services or pay insurance claims benefits.*
- *I have provided personal information relating to any third party, I confirm that I have received their consent for BF&M to process their personal information in line with the privacy notice.*

Privacy notice for health and medical data

At BF&M, we care about your privacy. We recognise that when you choose BF&M as your insurance provider, you are trusting us to protect your personal data.

In providing health and life insurance services to you and your family members, we need to collect and process sensitive personal data, such as medical and health details, belonging to you as the policyholder(s), as well as family members or other individuals who may be relevant to a policy or claim.

We want to be open and transparent with you about how we collect and use your personal data. Please read our Privacy Policy made available to you on our website at www.bfm.bm/privacy. If you have questions about how we handle your personal data, you can contact us at privacy@bfm.bm.

In accordance with our obligations under applicable data protection laws, we require your consent to process sensitive personal data. You may withdraw such consent at any time by contacting us at the above email address, but doing so may prevent us from providing insurance, administering existing policies or paying claims or benefits. The consent you provide will remain valid for the duration of the policy unless it is changed or withdrawn by you. A parent or guardian's consent will apply to any member who is a minor.

1. *Collection and processing: In accordance with its Privacy Policy and for the purpose of administering an insurance policy and providing related services, BF&M may collect and process my sensitive personal data. This includes collecting and processing my medical and physical or mental health data in order to administer the policy, including to quote for insurance cover, underwrite the risks, carry out renewals and to process claims.*
2. *Obtaining my personal data from third parties: In accordance with its Privacy Policy and for the purpose of administering an insurance policy and providing related services, BF&M may obtain my personal data, including health and medical data, from insurance market intermediaries such as agents or brokers who help arrange and administer my policy, any plan sponsor such as an employer who may set up a Health or Life policy as part of a group plan, physicians, nursing staff, paramedics and other hospital or laboratory staff, care homes, other medical institutions here in Bermuda and overseas, overseas insurers and claims' processing insurance services.*
3. *Sharing my personal data with third parties: In accordance with its Privacy Policy and for the purpose of administering an insurance policy and providing related services, BF&M may share my personal data including health and medical data with the categories of third parties listed below. I understand that BF&M requires these third parties to apply appropriate safeguards to protect my personal data and seeks contractual commitments and assurances.*

- *With service providers that perform services on behalf of BF&M, such as entities which perform medical and/or insurance risk assessments, handle and assist in the adjudication of claims made (without which BF&M would not be able to administer my policy or pay any claims), and other healthcare or wellness providers, providing healthcare services to me under my policy.*
- *With medical experts and institutions to assess insurance risks, policy coverage and claims made (without which BF&M would not be able to pay me or third-party medical providers for treatment given under an insurance policy).*
- *With other insurance market participants, such as co-insurers to distribute the coverage of insurance risk jointly with other companies to which BF&M issues a policy, and reinsurers that may be covering the same insurance risk at the same time.*

Name:	
Sign:	Date (dd-mmm-yyyy):

Please review all details carefully before submitting. Completed forms can be submitted via email to submitclaim@bfm.bm.

B. Cancellation

The following items must be included with this claim:

1. Copy of original itinerary
2. Terms and Conditions issued by Travel Agent and/or Transport, Tour or Accommodation Provider
3. Letter from Travel Agent or, where travel was not arranged through a Travel Agent, a letter from the relevant organisation through whom travel was booked, confirming payments made, refunds given and any amounts you are out of pocket
4. Proof of payment for trip (e.g. receipts, credit card/bank statements showing payments made)
5. If travel was cancelled due to Medical Reasons/Death – completed Medical Certificate (see last page of claim form) and copy of Death Certificate (if applicable)

Failure to provide these documents may result in delays in processing your claim.

What was the reason you could not commence or complete your proposed journey?	
Was your journey cancelled as a result of injury/sickness to yourself?	☐ Yes ☐ No
Was your journey cancelled as a result of injury/sickness to any other person? If yes, please provide full name:	☐ Yes ☐ No
Relationship to policyowner:	DOB (dd-mmm-yyyy):
Address:	
Nature of injury/sickness:	
Date travel was booked (dd-mmm-yyyy):	Date travel was cancelled (dd-mmm-yyyy):

Details of journey

Date (dd-mmm-yyyy)	Description of booking (e.g. flight details)	Merchant name (e.g. Expedia)	Currency (e.g. USD, KYD, EUR)	Amount paid (e.g. $250)	Refund received (e.g. $200)	Amount claimed (e.g. $500)
					Total amount claimed:	

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I/we agree to provide additional information to the Company, if required.

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- *If I have provided personal information relating to any third party, I confirm that I have received their consent for BF&M to process their personal information in line with the privacy notice.*

Name:	
Sign:	Date (dd-mmm-yyyy):

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C. Medical & emergency travel expenses

The following items must be included with this claim:

1. Copy of your Certificate of Insurance
2. Copy of original itinerary
3. Receipts, bank/credit card statements showing amounts paid by your for original itinerary
4. Proof of payment for additional expenses claimed (e.g. tax invoices, receipts, credit card/bank statements showing payments made)
5. If the additional expenses were incurred due to the unfortunate event of a death – a copy of the Death Certificate

Failure to provide these documents may result in delays in processing your claim.

Please state the reason/event that caused the additional expenses being incurred:

What was the unexpected expense incurred?

Please list each receipt/bill separately

Date (dd-mmm-yyyy)	Description of booking (e.g. hotel expense)	Currency (e.g. USD, KYD, EUR)	Amount (e.g. $500)
		Total amount:	

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We want to be open and transparent with you about how we collect and use your personal data. Please read our Privacy Policy made available to you on our website at www.bfm.bm/privacy. If you have questions about how we handle your personal data, you can contact us at privacy@bfm.bm.

In accordance with our obligations under applicable data protection laws, we require your consent to process sensitive personal data. You may withdraw such consent at any time by contacting us at the above email address, but doing so may prevent us from providing insurance, administering existing policies or paying claims or benefits. The consent you provide will remain valid for the duration of the policy unless it is changed or withdrawn by you. A parent or guardian's consent will apply to any member who is a minor.

1. *Collection and processing: In accordance with its Privacy Policy and for the purpose of administering an insurance policy and providing related services, BF&M may collect and process my sensitive personal data. This includes collecting and processing my medical and physical or mental health data in order to administer the policy, including to quote for insurance cover, underwrite the risks, carry out renewals and to process claims.*
2. *Obtaining my personal data from third parties: In accordance with its Privacy Policy and for the purpose of administering an insurance policy and providing related services, BF&M may obtain my personal data, including health and medical data, from insurance market intermediaries such as agents or brokers who help arrange and administer my policy, any plan sponsor such as an employer who may set up a Health or Life policy as part of a group plan, physicians, nursing staff, paramedics and other hospital or laboratory staff, care homes, other medical institutions here in Bermuda and overseas, overseas insurers and claims' processing insurance services.*
3. *Sharing my personal data with third parties: In accordance with its Privacy Policy and for the purpose of administering an insurance policy and providing related services, BF&M may share my personal data including health and medical data with the categories of third parties listed below. I understand that BF&M requires these third parties to apply appropriate safeguards to protect my personal data and seeks contractual commitments and assurances.*

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- *With medical experts and institutions to assess insurance risks, policy coverage and claims made (without which BF&M would not be able to pay me or third-party medical providers for treatment given under an insurance policy).*
- *With other insurance market participants, such as co-insurers to distribute the coverage of insurance risk jointly with other companies to which BF&M issues a policy, and reinsurers that may be covering the same insurance risk at the same time.*

Name:	
Sign:	Date (dd-mmm-yyyy):

Please review all details carefully before submitting. Completed forms can be submitted via email to submitclaim@bfm.bm.

D. Personal property

The following items must be included with this claim:

1. Copy of your Certificate of Insurance
2. Proof of ownership of the items claimed (e.g. duty, invoices, receipts, or credit card/bank statements proving purchase of the item(s))
3. Report made to the transport provider/police/hotel or other appropriate authority
4. Any photos showing Proof of Ownership

Failure to provide these documents may result in delays in processing your claim.

Give full details of how losses, damage or theft occurred (detail each event):

Date loss/damage occurred (dd-mmm-yyyy):	Time: ☐ am ☐ pm	Location/country:
Date loss/damage reported (dd-mmm-yyyy):	Time: ☐ am ☐ pm	Location/country:

Loss/damage reported to (police, airline or other authority): ☐ Yes ☐ No

Were items lost/damaged by carrier/airline? ☐ Yes ☐ No If yes, name the carrier/airline:

Have you made a claim or complaint against any carrier/airline or other authority or against any individual responsible for the loss or damage to your property? If YES, please provide details in the table below and attach copies of correspondence. If NO, you should proceed to claim with your carrier/airline before submitting your claim.

Are any of the other items covered by other insurance? ☐ Yes ☐ No If yes, which company:

Policy number:

Were all the missing items owned by you? ☐ Yes ☐ No If not, give details:

Details of missing items

Proof of purchase attached?	Articles claimed (e.g. ear buds)	Store purchased (e.g. Best Buy)	Date purchased (dd-mmm-yyyy)	Currency (e.g. USD, KYD, EUR)	Purchase price (e.g. $250)	Amount claimed (e.g. $200)
☐ Yes ☐ No						
☐ Yes ☐ No						
☐ Yes ☐ No						
☐ Yes ☐ No						
					Total amount claimed:	

Declaration

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I/we agree to provide additional information to the Company, if required.

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Name:	
Sign:	Date (dd-mmm-yyyy):

Please review all details carefully before submitting. Completed forms can be submitted via email to submitclaim@bfm.bm.

E. Delayed luggage expense claim

The following items must be included with this claim:

1. Copy of your Certificate of Insurance
2. Itemised receipts for the purchase of essential items claimed by you
3. Property delay/report from the carrier (e.g. bus line, airline, shipping line or rail authority) and confirmation of any compensation paid to you
4. Ticket and baggage tags from the carrier who caused your luggage to be delayed

Failure to provide these documents may result in delays in processing your claim.

Name of carrier/airline:	
Arrival date (dd-mmm-yyyy):	Arrival time: ☐ am ☐ pm
Date luggage was returned to you (dd-mmm-yyyy):	Time of return: ☐ am ☐ pm
What compensation was received from the carrier?	

Claims will be converted using the currency rate applicable at the date and time the expenses were incurred.

Proof of purchase attached?	Details of essential items purchased (e.g. toothbrush)	Date of purchase (dd-mmm-yyyy)	Store purchased (e.g. Target)	Currency (e.g. USD, KYD, EUR)	Purchase price (e.g. $2.50)
☐ Yes ☐ No					
☐ Yes ☐ No					
☐ Yes ☐ No					
☐ Yes ☐ No					
				Total:	

Declaration

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I/we agree to provide additional information to the Company, if required.

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- *If I have provided personal information relating to any third party, I confirm that I have received their consent for BF&M to process their personal information in line with the privacy notice.*

Name:	
Sign:	Date (dd-mmm-yyyy):

Please review all details carefully before submitting. Completed forms can be submitted via email to submitclaim@bfm.bm.

Medical Certificate

Instructions to the Medical Professional: Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Travel Insurance claim. To be completed by the patient's usual Doctor/Dentist (at the claimant's expense) in all cases of cancellation and medical claims resulting from accident, sickness or death.

Patient details

Name of person to whom the certificate applies: ____ DOB (dd-mmm-yyyy): ____

Address: ____

Are you the patient's usual medical practitioner? ☐ Yes ☐ No If yes, for how long? ____

If no, do you have access to their medical records? ☐ Yes ☐ No

To be completed by the Medical Professional (complete either section 1 or section 2)

☐ 1. Alteration to/cancellation of travel arrangements prior to travel

Did you recommend that travel be cancelled or postponed due to the patient's state of health? ☐ Yes ☐ No

On what date did you give this recommendation (dd-mmm-yyyy): ____

Please give precise details of the nature of the sickness or injury which gave risk to this recommendation (including the final diagnosis):

____

Did you fully explain the risk of traveling with this medical condition? ☐ Yes ☐ No

On what date did the patient first become aware of their symptoms (dd-mmm-yyyy): ____

Please describe the symptoms described by the patient: ____

On what date were you first made aware of the condition, or change in condition (dd-mmm-yyyy): ____

Has the patient previously been investigated, diagnosed or treated in respect to the same/similar sickness or injury? ☐ Yes ☐ No
If yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

Did the patient make the travel arrangements against your advice (or the advice of another medical practitioner)? ☐ Yes ☐ No

☐ 2. Treatment costs/additional expenses incurred during travel

What do you understand to be the sickness or injury which resulted in the need to seek medical care/interrupt the patient's travel plans?

____

Has the patient previously been investigated, diagnosed or treated in respect to the same/similar sickness or injury? ☐ Yes ☐ No
If yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

Was there any indication that medical care may be required on the journey? ☐ Yes ☐ No

Was the patient non-compliant with medical advice whilst on the journey? ☐ Yes ☐ No

Did the patient travel against your advice (or the advice of another medical professional)? ☐ Yes ☐ No

Declaration

I certify that the statements contained in this Medical Certificate are true and correct.

Doctor's signature:	Date (dd-mmm-yyyy):	Doctor's stamp:

Please review all details carefully before submitting. Completed forms can be submitted via email to submitclaim@bfm.bm.