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# Medical Expenses Claim Form

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Thank you for notifying us of your claim

Please complete all questions – if any question is not applicable please state 'N/A'

Please send the completed form together with all relevant correspondence to:

**U M Association Ltd, 5 St Helen's Place, London EC3A 6AB**

**Telephone: 020 7847 8670 Fax: 020 7847 8689 Email: [claims@umal.co.uk](mailto:claims@umal.co.uk)**

Name of Institution (University, College etc)	Certificate no.
<input type="text"/>	<input type="text"/>

Date on which travel commenced	<input type="text"/>	Date on which travel due to end	<input type="text"/>
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Full name of person covered (Mr, Mrs, Miss, Ms)	Date of Birth
<input type="text"/>	<input type="text"/>

Full address including postcode

Telephone no.	Email
<input type="text"/>	<input type="text"/>

Full name of other persons covered	Date of Birth	Relationship
1 <input type="text"/>	<input type="text"/>	<input type="text"/>
2 <input type="text"/>	<input type="text"/>	<input type="text"/>
3 <input type="text"/>	<input type="text"/>	<input type="text"/>

**Please ensure you sign the declaration on the last page of this claim form**

**Accident/Sickness Details**

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Type of travel: Business  Holiday  Placement  Internship

Please give exact date and place when injured or taken ill

Date  Place

Country in which incident occurred

**If accident**, please state fully:

a) Where the accident occurred

b) How the accident occurred

c) The injuries sustained

**If illness**, please state full details of the illness:

Has the person covered ever suffered from this illness before? YES  NO

If 'YES', please give details with relevant dates

Please state whether the person covered was in hospital YES  NO

If 'YES', please state dates of hospitalisation: Admitted  Discharged

Has the person covered previously claimed under this or a similar policy? YES  NO

If 'YES', please give details

Is the person covered covered under any group private medical scheme  
i.e. BUPA/PPP or any similar scheme? YES  NO

If 'YES', please give name, address and reference number of the company concerned

Did the person covered use a European Health Insurance Card  
(if treated within the EU)? YES  NO

**Details of Expense**

All accounts bills, receipts, medical certificates, booking invoices, any correspondence and any other documents relative to this claim should be forwarded to the company

Claimant name	Nature of expense	Name and address of doctor or hospital attended	Currency of expense	Amount £	Paid ✓
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>
					<input type="checkbox"/>

Total £

Please ensure you provide original receipts/invoices for all expenditure

We have updated our [Privacy Policy](#), to ensure that we continue to handle your data fairly and lawfully, in accordance with the General Data Protection Regulation that came into force on 25 May 2018.

You can review the updated Privacy Policy [here](#).

The Privacy Policy includes information and guidance, such as:

- How we collect, use and store your personal data;
- Your rights in connection with our collection, use and storage of your personal information;
- The circumstances under which we may be obliged to share your personal data with third parties.

By signing this form, you are consenting to the terms of our Privacy Policy.

If you have any questions about our Privacy Policy, you can contact the Data Protection Officer on 020-7847 8670, or by email to [DPO@umal.co.uk](mailto:DPO@umal.co.uk), or by writing to the Data Protection Officer at 5 St Helen's Place, London EC3A 6AB.

## Declaration

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**Please remember to print this form and sign in the space below before sending the completed form – either in hard copy or as a scanned PDF to the contact details shown at the top of page 1**

Name	Signature
Position	
Date	

Please ensure:

- You have completed ALL relevant questions on this claim form.
- You have enclosed ALL requested information/documentation.
- You have signed this claim form.

As failure to do so will result in delay in handling your claim.

Thank you for fully completing this form.