CREW EXPENSES



YACHT	TREATMENT DETAILS
Name of Yacht	Please advise what treatment you have received
PERSONAL DETAILS (Claimant / Patient)	due to this accident / illness.
Name	
Date of Birth Male Female	
Address	
	Please advise any further ongoing treatment you will/may be obtaining due to this accident / illness.
Phone No Fax no	
E-Mail	
Nationality	
Position on board	If the claim is due to ILLNESS have you previously received
CLAIM DETAILS	medical treatment in respect of the same Illness or for similar symptoms?
Is the Claim / Medical Expenses due to an	YES NO
ACCIDENT ILLNESS	If YES please provide details including dates symptoms first
If due to an ACCIDENT please state date of occurrence, If due to ILLNESS please state date which symptoms first appeared.	appeared and last date of treatment.
If due to an If due to an ACCIDENT please describe the circumstances leading to your accident. / If due to ILLNESS please describe the cause of your illness.	
	OTHER INSURANCE
	Are you covered under any other Insurance?
	YES NO
DOCTOR'S DETAILS	If YES ,
Please advise doctor / medical providers Name,	Name of Insurer
Address and Contact details.	Policy Number
Name	Contact details
Contact details	Contact details

SUMMARY OF CLAIM

In order to fully proce	ss your claim pl	ease list and detail each invoice pr	rovided	
Invoice Number	Date	Doctor / Medical Provider	What type of service was provided	Cost
			Total Claim Amount	
ACCESS TO ME	DICAL REPO	ORTS ACT 1988		
, ,			or, However, before Underwriters can apply for a e foot of this page, you should read the followin	
(A) You can withhold y	our consent but	t if you should do so your insures r	may be unable to process your claim.	
		sent to insurers, or during the six		
		- · · · · · · · · · · · · · · · · · · ·	ou can ask the doctor if he/she will amend any pot in agreement you may append your own con	
		the report, or part of it, if they think		
CONSENT TO O	BTAIN A ME	EDICAL REPORT		
I have been informed of my statutory rights under the Access to Medical Reports Act 1988 and, in accordance with my insurance claim, hereby consent to the underwriters being provided with medical information from any doctor who at any time has attended me concerning anything which affects my physical or mental health and I agree that a copy of this concent shall have the validity of the original.				

DECLARATION

I wish to see the report before it is sent to the Insurers I do not wish to see the report before it is sent to the Insurers

I certify that all information contained in this form is true, correct and complete to the best of my knowledge.

Signed **Dated**

