

TRAVEL MEDICAL EXPENSES CLAIM FORM

PRIVACY NOTICE

By completing this form, you will have provided NCBA Insurance Company Limited (NCBA Insurance) with your Personal Data. Personal Data is any information that identifies you or other individuals named in this form. Please note that you should only provide Personal Data about someone else to us with the individual's express permission. NCBA Insurance will, in adherence to the principles of data protection, collect, store, use, transfer (including cross-border), and disclose certain Personal Data in connection with the provision of insurance services. You have a right to be informed of the use to which your Personal Data is to be put; a right to access your Personal Data in our custody and to request us transfer it to another organization; a right to object to the processing of all or part of your Personal Data; a right not to be subject to a decision based solely on automated processing; a right to correction of false or misleading data; and to deletion of false or misleading data about you. Detailed information about how we use Personal Data is set out in our Privacy Policy, which you can find at <https://ke.ncbagroup.com/privacy-policy/>.

SECTION A : PERSONAL DETAILS

First Name: _____ Surname: _____
Date of Birth: _____ Occupation: _____
Nationality: _____ ID Number: _____
Postal Address: _____ Postal Code: _____ Town: _____
E-Mail Address: _____ Mobile Phone: _____

SECTION B : POLICY INFORMATION

Policy Number: _____ Name of policy: _____
Date issued: _____ Policy start date: _____ Policy end date: _____
Date the loss occurred: _____ Number of insured travellers: _____
Please advise the section(s) of the policy you are making the claim under: _____
Total amount claimed: _____

SECTION C : TRAVEL DETAILS

Booking reference: _____ Booking Date: _____
Tour operator: _____
Departure date: _____ Return date: _____ Total days: _____ No. in party: _____
Destination country: _____ Destination city: _____

SECTION D : ELECTRONIC FUNDS TRANSFER DETAILS

You should ensure that your payment details are correct on this form. We shall not be responsible for any incorrect payments or delays arising as a result of the provision of incorrect information. We cannot accept responsibility for the security of the information on this form until it is received by us. We recommend you provide a cancelled cheque.

Name of the account holder: _____
Name of the bank: _____
Address of the bank: _____
Branch Code: _____ Currency of the account: _____
IBAN / Account Number: _____ SWIFT / BIC Code: _____

SECTION E : MEDICAL EMERGENCY AND ASSOCIATED EXPENSES

1. Date and time the illness or injury occurred. Date _____ Time _____

2. Was the medical Assistance company contacted? Yes No

If NO, please explain reason for not contacting the assistance company then move to question 4:

2a. Assistance case reference No.: _____

3. Date Admitted: _____ **Date Discharged:** _____

Please outline the ILLNESS or INJURY which gave rise to the medical claim

4. If your medical claim was a result of an INJURY: Was a third party involved? Yes No

If YES, please provide their name, address and their insurance/solicitors details:

5. If your medical claim was a result of an ILLNESS: Have you ever suffered from this illness before? Yes No

If YES, please provide details:

6. Hospital/Clinic details

Name: _____

Address: _____ Telephone: _____

Treating Doctor: _____ Patient Number.: _____

7. Medical and associated expenses.

Please number all your receipts and reference that number in the column labelled "Receipt No" in the table below.

We will use an exchange based on the monthly average for that currency unless you provide bank statements or Bureau de Change receipts showing the exchange rate used by you at the time.

Please submit your receipt confirming the appropriate excess has been paid. If you have not paid your excess then your claim will be reduced by the excess amount set out in the terms of your policy.

No	Date	Description	Invoiced from	Currency	Amount	Exchange rate	Paid Y/N

8. Medical Aid details:

PLEASE NOTE: Where 2 policies cover the same loss it is normal practice for both insurers to share the cost. Please therefore provide details of your Medical Aid in the boxes below

Name of Product: _____ Policy Number: _____

Address: _____ Contact Phone number: _____

SECTION F : DECLARATION AND AUTHORITY

Privacy Consent

Where you have shared sensitive personal information, including your health status, property details, and family details, we require your explicit consent for cross-border transfer. By ticking the box below, you consent to the international transfer of the sensitive personal information for policy management, claims processing, and customer support. Your data will be protected under appropriate safeguards, and you may withdraw your consent at any time by contacting ncbainsurance@ncbagroup.com.

I consent

I do not consent

Declaration

I/We declare that the above information is true and correct and that the signing of this claim form also constitutes written authority for NCBA Insurance to inspect or investigate any medical records or details relevant to this claim. I/we further declare that i/ we are aware that any misrepresentation and / or non-disclosure in respect of information provided herein shall render my/our claim null and void.

Name: _____

Signature: _____ Date: _____

(If Corporate)

Name: _____

Designation: _____

Company Stamp and Date: