DiveAssure Claim Form

In case you require Emergency Medical Assistance please telephone +44 (0)20 3137 3673 immediately or email: ops@northcottglobalsolutions.com .

NGS has been appointed to provide emergency medical assistance services and DiveAssure Claims to handle your claim recovery. To help us process your claim quickly, please follow these guidelines:

1. Complete a **separate claim form** for each claim and for each insured person.
2. If you are submitting **a claim following an illness, accident or injury**, please complete in full Sections A, B, J & K.
3. If you are submitting **a claim for a non-medical incident or personal luggage loss**, please complete Sections A and E - J as appropriate.
4. If you are submitting **an accidental death claim**, please complete Sections A, D, J & K.
5. Please email this fully completed form to the **claims@diveassure.com** with ALL original bills relating to the claim, plus proof of travel (e.g., email confirmations of trip, booking invoices, tickets.) All submissions MUST be received by NGS Advent **within 90 DAYS** of the date of the loss or commencement of treatment.

A. PRIMARY INSURED DETAILS		
Name (Last, First, MI):		Policy Number:
Address:		
Postal Code/Zip:		Phone Number:
E-mail:		
Policy Currency: ☐ US$ ☐ € ☐ Other (specify)		A claim deductible may apply to each benefit. The maximum benefit and policy excess currency is determined by the currency with which your Travel policy was purchased.
CLAIMANT DETAILS (if different from above)		
Name (Last, First, other):		
Address:		
Postal Code/Zip:		Phone Number:
Occupation:		
Was journey for:	☐ Personal	☐ Business
Dates of journey: (DD/MMM/YYYY, i.e., 01/MAY/2015)	From:	To:
Is the claim the result of an accident?	☐ Yes	☐ No

DECLARATION

For Data Protection Purposes, I/We acknowledge that any personal data secured from me/us as a result of this claim will be held and processed for insurance administration and claims investigation. For this purpose, the information may also be passed to selected third parties and reinsurers.

- I/We consent to your processing of sensitive data about me/us and other persons who may be insured under the contract.
- I/We understand that all personal data I/We supply must be accurate and I/We have the specific consent of those other persons insured to disclose their personal data.
- I/We consent to the inquiry of information from other insurers, Credit and other information Agencies to check the answers we have provided and will authorize the release of such information.
- I/We declare that on settlement I/We transfer all rights of subrogation and recovery to the Insurer and or/their Loss Adjuster. Please note that we have rights to salvage and/or recovery and we will exercise these rights where applicable.
- I/We declare that, to the best of our knowledge, the information submitted in this form is correct and complete.

A copy of our Data Privacy Policy is available on request.

Insured Person	Primary Insured/Policyholder (if different)
Name:	Name:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.

B. MEDICAL EXPENSES & HOSPITAL BENEFIT

Nature of illness/injury:	
Date illness/injury occurred (MM/DD/YYYY):	Time illness/injury occurred:
Where the illness/injury occurred:	
Please provide a detailed description of how the injury occurred:	
Name of claimant's personal family physician / doctor (even if not consulted):	
Personal family physician/doctor's address:	
Phone Number:	Email:
Name and address of doctor(s) and/or hospital(s) from which the treatment was received:	
If treatment was given in hospital as an in-patient please confirm the dates:	
Was the Emergency Assistance Company contacted: ☐ Yes ☐ No If no, please state the reason why not:	
Was the Insured Person Pregnant: ☐ Yes ☐ No If yes, how many weeks?	
If the Insured Person has suffered illness, has he/she suffered from this before: ☐ Yes ☐ No If yes, please provide details:	
Does the Insured Person have Private Medical Insurance: ☐ Yes ☐ No If so, please provide the insurance carrier details including name, address and policy number:	
Amount being claimed:	

FOR EU CITIZENS ONLY

Was an EHIC (European Health Insurance Card) taken on the trip ☐ Yes ☐ No Was this presented to the hospital/doctor? ☐ Yes ☐ No

C. QUARANTINE EXPENSES

Date of Covid-19 Diagnosis:	Period of Quarantine:
Country of Quarantine:	Accommodation Expenses:
Other Expenses:	
Amount being claimed:	

D. ACCIDENTAL DEATH

When did the fatality occur?

Please detail how the death occurred:

Was the cause of death a result of natural causes?: ☐ Yes ☐ No
If yes, please give details:

Amount being claimed:

In the event of a fatality, a Death Certificate issued by a licensed authority must be obtained, with the original copy being submitted to **claims@diveassure.com**

E. CANCELLATION OR CURTAILMENT

When was the journey booked (MM/DD/YYYY):

When was the journey cancelled/curtailed (MM/DD/YYYY):

Please provide a detailed explanation of why the journey was cancelled/curtailed:

If the cancellation was not due to the person travelling, please confirm the name of the person who caused the trip to be cancelled and his/her relationship to the person(s) travelling:

If the journey was curtailed, was the Emergency Assistance Company contacted? ☐ Yes ☐ No

Were any additional expenses incurred? ☐ Yes ☐ No
If yes, please provide details below and send all invoices/receipts with this claim:

Please confirm to whom reimbursement should be made payable:

Amount being claimed:

ADDITIONAL DOCUMENTS REQUIRED

If the journey was cancelled due to injury/illness of the person travelling, we require written confirmation from the General Practitioner that the Insured Person was unfit to travel.

If the journey was cancelled due to the injury/illness of a third party, we require written confirmation from the third party's General Practitioner confirming the injury/illness.

Please also provide:

- Documentation in support of the cancellation of the trip for any other factor not described above.
- Original booking invoice.
- Cancellation invoice showing the charges incurred.

F. LOST DIVING DAYS
Original dive dates (MM/DD/YYYY):
Lost diving days dates (MM/DD/YYYY):
Please provide a detailed explanation of why the dive days were lost:
Amount being claimed:
ADDITIONAL DOCUMENTS REQUIRED
If diving days were cancelled due to injury/illness of the Insured, we require written confirmation from the General Practitioner that the Insured Person was unfit to dive. If diving days were cancelled due to injury/illness of a third party on board a vessel, we require written confirmation from the boat captain, trip provider or trip leader. If diving days were cancelled due to weather conditions, we require written confirmation from the boat captain, trip provider or trip leader. Please also provide: • Documentation in support of the cancellation of the dives for any other factor not described above. • Original dive booking invoice.

G. TRAVEL DELAY / MISSED DEPARTURE	
Reason for travel delay/missed departure:	
TRAVEL DELAY	
Schedule date and time of departure:	
Flight/Ferry/Other Transport Number/Ref:	
Actual date and time of departure:	
Flight/Ferry/Other Transport Number/Ref:	
Number of hours delayed:	
Airline/Ferry/Other Transport Company Name:	
Amount being claimed:	
MISSED DEPARTURE	
Point of departure:	Point of Missed Connection:
Method of transport used to arrive at departure point:	
Please confirm how you recommenced your trip:	
Amount being claimed:	

H. BAGGAGE, PERSONAL EFFECTS, MONEY & DOCUMENTS

Date of loss or damage (MM/DD/YYYY):	Time:
Please provide a detailed description of how the loss/damage occurred, including the location:	
Please confirm when the loss/damage was reported and to which authority (e.g., police/airline/tour operator/hotel, etc.), including complete address and reference:	
If the loss relates to traveler's cheques, cheques, cash, credit, bankers/charge card, provide date that the issuer was notified:	

ITEM DETAILS

Full description of item 1:		
Where purchased:	Date purchased (MM/DD/YY):	
Price Paid:	Cost Now:	Amount being Claimed:
Full description of item 2:		
Where purchased:	Date purchased (MM/DD/YY):	
Price Paid:	Cost Now:	Amount being Claimed:

ADDITIONAL INFORMATION

Provide details of any other insurance policy that you have whether or not you think it may contribute to this loss, e.g., household insurance, private medical insurance, personal travel insurance, credit card insurance, etc.:	
Name of Insurer:	Policy Number:
Address:	

ADDITIONAL DOCUMENTS REQUIRED

- In the event of a personal baggage loss, all incidents MUST be reported to the local police within 24 hours. An incident number and loss report must be obtained and submitted to **claims@diveassure.com.**
- If the loss occurred at the airport or on the aircraft, the incident MUST be reported to the airline within 24 hours through an Incident Report. We require the Incident Report to be sent with this claim form.
- Provide proof of the original purchase/ownership, i.e., receipts, bank/credit card statements, photographs, packaging, instructions manuals, valuations.
- Please note that we may make a deduction on the claim if proof of purchase is not provided and/or if wear-and-tear is applicable.
- If items have already been replaced, please send the replacement invoice or receipt.
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I. LOSS OF PASSPORT

Please confirm where the passport was lost:
Please provide details of the expenses incurred to replace the passport, including receipts:

J. REIMBURSEMENT METHOD

Our preferred payment method is electronically to ensure that you receive your payment as soon as possible although we are able to issue checks in most countries.

Please reimburse: ☐ Primary Insured ☐ Provider

Bank Name:
Name on Account (payee):
Account #/IBAN:
Routing #/ABA #
Sort code or SWIFT code:
Bank Address:

K. AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I hereby authorize any physician or other healthcare professional, hospital or healthcare-related facility, pharmacy, medical service provider, employer, benefit plan administrator, and any Federal, State or Local Government Agency, with a complete copy of any and all medical information for use and disclosure as described in this authorization. Further to release any medical and other information in your possession or control to **DiveAssure Claims** and/or their attorneys, either directly or through a representative agent acting on their behalf, any and all medical information they may request, including but not limited to, medical records, reports, charts, graphs, x-ray notes, films, and laboratory reports.

I also hereby authorize the release of all medical information regarding diagnosis, care and treatment for alcohol abuse, drug abuse or mental health. In addition, I authorize the release of any and all billing records and statements in your possession or control.

I also authorize **DiveAssure Claims**, their representatives or their agents to release information that is obtained pursuant to this authorization to providers of healthcare, insurers, reinsurers, or claims administrators, and any government agency as it deems appropriate solely for the purpose of evaluating and administering any claim for benefits. I further understand that information may be released as follows:

To other persons or organizations performing business or legal services in connection with any claim; As may be otherwise lawfully required;

- To any person or legally authorized representative as I have so indicated;
- As I may further authorize; or as necessary to prevent or detect the perpetration of fraud.

This "Authorization For Release of Medical Information" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature. I agree that a photocopy, e-mailed copy or facsimile (FAX) copy of the authorization shall be accepted and as valid as the original. I know that I may request to receive a copy of this Authorization.

Name:	Date:

Signature:

By typing my name on this form, I am signing electronically, and this electronic signature is the legal equivalent of my manual, handwritten signature.

Please send completed claim form and supporting documents (**INCLUDING PROOF OF TRAVEL**) to:

DiveAssure Claims:
claims@diveassure.com

For any questions or queries relating to your claim please telephone +1-866-898-0921 ext. 1

Privacy Notice

Personal data is collated and held in assessing your claim and this is subject to our Privacy Notice. A copy of this Privacy Notice and how your personal data is used and held is available upon request

Personal Representative Authorization Form

Please submit the completed claim form and ALL supporting information and documentation to DiveAssure Claims: **claims@diveassure.com**

A. INSURED	
Name (Last, First, MI):	
Policy #:	Claim #:
Date of Birth: (DD/MMM/YYYY, i.e., 23/NOV/1988)	
Address:	
Postal Code:	Country:
Phone:	Email:
B. PERSONAL REPRESENTATIVE	
Name (Last, First, MI):	
Date of Birth (DD/MMM/YYYY):	
Address:	
Postal Code:	Country:
Phone:	Email:

C. AUTHORIZATION

I authorize that the confidential information held by DiveAssure Claims be released to and/or received by persons or organizations indicated below with your signature. I understand that I am entitled, upon request, to receive a copy of this signed form.

I hereby authorize the request and release of my confidential information held to my personal representative. By appointing the person named below as my personal representative, I understand that I am authorizing to give this person access to my confidential information and medical records, the right to talk to about my medical care and the right to make decisions that will bind me.

This "Personal Representative Authorization" is subject to revocation at any time except to the extent that action has been taken in reliance hereon and, if not earlier revoked in writing, it shall remain valid for two (2) years from date of signature. I agree that an e-mailed copy of the authorization shall be accepted and as valid as the original. I know that I may request to receive a copy of this Authorization.

Insured Person	**Personal Representative**
Name:	Name:
Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.	Signature: By typing my name on this form, I am signing electronically and this electronic signature is the legal equivalent of my manual, handwritten signature.
Date:	Date:

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