PANTAENIUS
Yacht Insurance

Claim Form – Crew Medical

Please complete this claim form and return it to: Pantaenius UK Ltd.

- Complete a separate claim form for each illness/accident, and each Insured Person
- Ensure that the Doctor who treats you completes the section overleaf.
- Send this fully completed form to Pantaenius, together with the original bills for the treatment received, within 90 days of the start of the treatment

Section A: Patient Information (To Be Completed By the Patient or his Legal Representative)

Full Name of Patient:		Date of Birth:		
Policy Number:		Sex: *(Please indicate)*	Male:	Female:
Full Mailing Address of Claimant:				
Telephone No:		Fax No:		

Section B: Claim Information (To Be Completed By the Patient or his Legal Representative)

Please state nature of illness:	
Please state date on which symptoms first occurred:	
If the cause of illness relates to an accident, please state the date of the accident and give brief details of the circumstances and injuries received:	
Please give the name and address of your personal Physician (G.P.)	
Is this a continuation of previous or current treatment for which you have already claimed under this plan? If "Yes", please state your claim reference number.	

Please list expenses for which reimbursement is being claimed			
Date(s) of treatment	**Currency**	**Amount(s) paid**	**State to whom you wish settlement to be made**

N.B. - Unless we are advised otherwise, settlement of your claim will be made in the currency of your policy.

AUTHORIZATION: (this must be signed by the patient, or his/her legal representative)
I hereby declare that the above answers are true and complete to the best my knowledge and belief. I authorize the release of any medical information to the insurer or to pantaenius acting on behalf of the insurer as required to settle all eligible benefits. A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of Insured Person (or legal representative):	Date:

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The following questions must be answered and signed by the treating Physician or Hospital:

Please state the date on which the first symptoms of the sickness/accident occurred:	
Please state the date on which the patient first consulted you:	
Please state the name and address of the referring physician:	
Telephone:	Fax:
Please give your diagnosis of the illness/injury:	
Will the illness/injury require further follow-up treatment? If "Yes", please give details including the estimated date of completion of treatment:	
Please give a history of this or any related condition, with dates on which any previous treatment took place:	
Have you any reason to believe that treatment for the same or any related condition has been given previously? If "Yes", please give details:	
Please print your name and address:	
Telephone:	Fax:
Please sign	
Signature of the Treating Physician:	Date:
Office use only	
Date received:	Date processed: