

Policy Number: _____

Personal Details of all people claiming

Title	Full Name	Date of Birth	Occupation	Usual Country of Domicile

Contact Details

Claimant Address: _____

Postcode: _____

Daytime Telephone: _____

Email Address: _____

Wherever possible we will try and communicate with you by Email or telephone for a quicker service.

Travel Details

Travel Destination: _____ Country: _____

Resort: _____

Date of booking: _____

Departure date: _____

Return date: _____

Purpose of Trip: Business Pleasure Other

If you are on a multi destination trip please list all the countries visited?

Dual Insurance Details

Please confirm if you or anyone else claiming has any other insurance policy that may cover this event. This may include cover provided by your household insurer, Credit Card Company, bank account or travel booking agent.

Yes

No

If Yes please provide details of the other company including where relevant full contact details, policy number or bank account number.

Please note there is an agreement between most travel and household insurers that if we seek a contribution of any outlay made by Accident & Health Claims Services LLP then your "No-Claims" status will not be impacted.

For Medical Related Claims:

I authorise any doctor, hospital or other organisation or person having any records or information concerning my medical history or treatment to furnish such records or information as may be requested by Accident & Health Claims Services Limited. I understand that in executing this authorisation, I waive the right for such information/records to be privileged. I am also aware that such information/records are relevant in the evaluation of my claim and that non-submission could prejudice my claim. A photocopy of this authorisation shall be considered as effective and valid as the original.

Name

Signed

Relationship to claimant if applicable

Dated

If your claim is agreed how would you like to be paid?

- Please note payment directly into your bank account will be quicker than sending a cheque.
- If the payee name differs from the Assured as stated on the Schedule of Insurance a mandate on the Assured's letter headed paper will be required before payment can be issued.
- For payments into non UK bank accounts we can only arrange payment into the final receiving bank and not through an intermediary.

Preferred Payment Method	Bank Details
<input type="checkbox"/> Cheque	<input type="checkbox"/> Confirm Payee: _____
<input type="checkbox"/> BACS (UK Bank Accounts only)	<input type="checkbox"/> Name of Account Holder: _____ Account Number: _____ Sort Code: _____
<input type="checkbox"/> Wire Transfer (payments into Non UK bank Accounts)	<input type="checkbox"/> Bank Swift Code: _____ For payments to all countries. Bank IBAN : _____ For payments to all European countries. Account Number: _____ Name of Account Holder: _____ Country of Bank: _____

Travel Cancellation Claim Form

Please indicate your reason for Cancellation:-

Death <input type="checkbox"/>	Illness <input type="checkbox"/>	Injury <input type="checkbox"/>	
Redundancy/Jury Service <input type="checkbox"/>	Damage/Theft of Property <input type="checkbox"/>	Adverse Weather <input type="checkbox"/>	

Please provide details of the reason for cancellation (continue on a separate sheet if necessary)

If the reason for cancellation is due to the death, illness or injury of a non travelling person please confirm their name and relationship to you.

If the reason for cancellation was due to an accident, please provide details and confirm who was at fault and why. If the accident was the fault of a third party please provide contact names and addresses, plus details of the relevant police authority.

Travel Cancellation Claim Form

Please confirm:-

The date and time you became aware of the need to cancel your trip?

The date and time you informed your booking agent of the need to cancel?

The holiday/trip costs:-

- Ticket Costs
- Accommodation Costs
- Pre Booked Excursions
- Deduct refunds received or advised
- Total amount claimed

Documents required to support a cancellation claim

You will need to send us the following original documents. Please keep copies for your own records.

- Booking invoice and/or confirmation of trip costs
- Cancellation invoice showing any refund due.
- For death, illness or injury claims the attached medical certificate needs to be completed by the relevant GP. The completion of the medical certificate is at your own expense. Unfortunately, a death certificate is not sufficient for our needs and we will need the medical certificate completed.
- For redundancy claims we will need a letter from the company confirming the redundancy and the dates of employment, together with confirmation of the employment status held.
- For jury service claims we shall require sight of the letter from court confirming your attendance.
- For property damage/theft claims we shall require a letter from the police confirming your attendance at the property was necessary. For major damage to property we shall require independent proof of the incident.
- For adverse weather claims we shall need proof that it was not possible for you to reach your departure point and confirmation of the reason why.

Travel Cancellation Claim Form

Medical Certificate – to be completed by the usual Medical Practitioner of the person who gives rise to the claim. Please note any charge made for the completion of this medical certificate is the responsibility of the claimant and is not refundable under the insurance cover.

Full name of the patient;

Date of Birth

Are you the above named usual GP?

If yes for how long?

Please state the precise medical condition, illness, injury or cause of death, that gives rise to the claim.

Please state the exact date the patient first consulted you with the symptoms of this condition

Please state all medical conditions the patient has sought treatment or investigation (whether inpatient or outpatient) for within the last 24 months.

Please list all medication the patient regularly takes and confirm the date of the last prescription and change in dose if applicable.

Please continue on a separate sheet if necessary

Has the patient received a terminal prognosis? If yes please provide date and prognosis?

If claim is as a result of pregnancy please confirm the following:-

Date pregnancy confirmed LMP ECD

Was the claimant required to cancel the trip solely due to the medical condition named above?

Please state the exact date you advised the claimant of the need to cancel

I have examined the patient and/or referred to his/her medical records and I declare that the information given is correct and that no details relevant to the case have been omitted.

Name (please print)..... Qualifications.....

Signature..... Surgery Stamp

Date