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 insures 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	
Cheque	☐	Confirm Payee:	
BACS (UK Bank Accounts only)	☐	Name of Account Holder: Account Number: Sort Code	
Wire Transfer (payments into Non UK bank Accounts)	☐	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:	

Declaration

All Claimants over the age of 16 must sign below otherwise the claim form will need to be returned to you and this will result in a delay in handling your claim.

It is against the law to submit a fraudulent insurance claim which includes deliberately exaggerated claims. All types of fraud are taken seriously and if your claim if found to be in any way fraudulent then the claim will be declined and the Underwriters of the policy reserve the right to pursue a recovery by the use of civil action.

- I/We hereby declare that all information, documents and answers to questions given on this claim form are correct and true to the best of my/our knowledge. I/We have not omitted any information which would affect the Underwriters judgment of the claim.
- I confirm that where a claim or claims are made on behalf of others, I have the other claimant's full authority to act on their behalf and I confirm that I understand that neither Accident & Health Claims Services LLP nor the Underwriters of the Insurance will accept any responsibility if any payments are not distributed proportionately to the persons concerned.
- I/We understand that the information on this form will be passed to or used by Accident & Health Claims Services LLP for my insurance; this includes underwriting, processing, handling claims and preventing fraud. This could include passing details to agents or other Insurers.
- I/We subrogate all rights of recovery to Accident & Health Claims Services LLP and also consent to them seeking reimbursement of any claims expenses paid by them.
- I/We agree to Accident & Health Claims Services LLP to contact my household insurers or medical insurers or other travel insurers regarding a contribution.

I agree that I have read and fully understood the above declarations.

Claimants Name	Claimant Signature	Date Signed

Curtailment Claim Form

Please indicate your reason for claiming:-

Illness	☐	Injury	☐	Illness or injury of a non-travelling person	☐

Date and time you were aware curtailment was necessary:	dd/mm/yy HH:MM
Name of clinic or hospital where treatment was sought:	
Treating Doctor's name:	
Date and time of admission (if applicable):	dd/mm/yy HH:MM
Date and time of discharge (if applicable):	dd/mm/yy HH:MM

Please provide full details of the illness or injury suffered and any other relevant information.
If you have suffered an injury as a result of an accident caused by a third party, please provide their full details.

If the reason for Curtailment relates to a non-traveling person, please complete the following. The medical certificate attached will also need to be completed by the usual Doctor of the person who gives rise to the claim. Please note any fee charged for completing the medical certificate is the responsibility of the claimant

Name of person giving rise to the claim:

Relationship to you of the person named above:

On what date did you return to your country of domicile:

Please confirm the number of days of your trip that were unused:

Expenses Incurred

Please list the expenses you wish to claim for (continue on a separate piece of paper if necessary).

Date	Description of Expense	Invoice From	Amount paid and currency	Sterling Equivalent	Paid Y/N

Documents required to support a Curtailment claim

- Original invoices to support the amount claimed.
- Medical report from the treating Doctor.
- Medical certificate if the reason for the claim is due to the illness or injury of a non-travelling person.

Travel Curtailment 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 dd/mm/yy

Are you the above named usual GP? Y/N 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 dd/mm/yy

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? Y/N

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

Date pregnancy confirmed dd/mm/yy LMP dd/mm/yy ECD dd/mm/yy

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

Please state the exact date you advised the claimant of the need to cancel dd/mm/yy

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 ……..