

**CLAIM FORM FOR TRIP CANCELLATION, CURTAILMENT OR
REARRANGEMENT**

(to be completed by the person who purchased the insurance)

Section 1

Your Details

Mr / Mrs / Miss Forename : _____ Surname : _____

Address : _____

Postcode : _____

Daytime telephone number : _____

Occupation : _____ Date of Birth : _____

E-mail Address: _____

Section 2

Details of Your Trip

Date holiday was booked : _____ Destination : _____

Date Deposit was paid for holiday : _____ How much paid ? : £ _____

Date final balance was paid : _____ How much paid ? : £ _____

Date Insurance purchased : _____ How much paid ? : £ _____

Certificate/Policy number : _____

Scheduled date of departure : _____ Scheduled date of return : _____

If you did not return on the scheduled date, what date did you return : _____

Section 3

Details of your Claim

Did you have to cancel () or curtail () or rearrange () your trip – please tick as appropriate

Please give reasons for cancellation, curtailment, or rearrangement (use separate sheet if necessary) : _____

Who did you notify of the above : _____ on what date? : _____

Please give name of person necessitating the cancellation, curtailment or rearrangement: _____

Was the above named person due to travel / did travel with you? : _____

What is your relationship with the above named person? : _____

Please give the Date of Birth of the above named person : _____

If you had to curtail all or part of your holiday please state which parts were missed : _____

Have you received any refunds in respect of your cancellation, curtailment or rearrangement from any third parties ?

Yes () No ()

If yes please give : Name of third party : _____

Amount refunded : £ _____

Date of Refund : _____

Please state amounts being claimed and for what the amounts are claimed :

Amount	Claimed For
_____	_____
_____	_____
_____	_____
_____	_____

(please use additional sheet if necessary)

Please use the space below to give any additional information you feel is relevant to your claim :

Section 4
Declaration

Important : Please read this declaration before signing. No claim will be paid unless the declaration is signed.

I understand that the making of a fraudulent insurance claim is a criminal offence likely to lead to prosecution.
I confirm that the information given on this claim form is, to the best of my knowledge and belief true in every respect and the amounts claimed have not been exaggerated, refunded to me or claimed from any other source.

Signature: _____

Date : _____

Section5

Medical Certificate

The claimant must at his or her own expense have the following certificate completed by a duly qualified medical practitioner. The certificate below relates to the person whose state of health caused cancellation, curtailment or rearrangement.

Name of person to whom these medical details apply : _____ (Patient)

Date of Birth of the Patient : _____

Are you the Patients usual medical practitioner ? YES () NO () Please tick as applicable.

How long have you been treating the Patient ? _____

When did you first treat or consult the Patient for the illness or injury which has occasioned the cancellation or curtailment ?

Date of onset of illness or date of the injury : _____

Please give a brief account of the course and prognosis of the illness / injury : _____

Has the Patient ever suffered from this or any similar or related condition ? YES () NO () If YES please give full details (please use separate sheet if required) : _____

Was the Patient taking any medication or under any treatment ? YES () NO () If YES please give full details :

Did the Patient consult you for permission to travel before booking the trip ? _____

Do you consider the patient was fit to travel at the time of booking the trip ? _____

Did you advised the patient to cancel the trip: _____ If so please give date : _____

Do you consider the cancellation, curtailment or rearrangement justifiable on medical grounds ? _____

If cancellation was due to pregnancy please give : Date of confinement : _____

Date pregnancy confirmed : _____

General remarks : (please use separate sheet if necessary)

Signature : _____ Date : _____

Practice Stamp (please include address and telephone number if not on stamp):