

Dear Sir/Madam,

Following your request for a claim form please find this now enclosed.

So that we may process your claim as quickly as possible please ensure that you fully complete and sign all the relevant sections and return it to us with the following **ORIGINAL** documentation: (Please note that should you require your original documents returned, you must request this in writing within 90 days of submitting your claim).

<b>Documents Required</b>	<b>Enclosed</b>
1. Insurance policy schedule/certificate of insurance showing payment of your insurance premium.	
2. Original evidence to substantiate travel. E.g. Booking invoice, travel itinerary and/or tickets.	
3. All unused and used travel tickets, itineraries etc.	
4. If curtailment is due to the medical condition, including death, of someone in the UK please have the attached medical certificate completed by the usual medical practitioner of the individual whose condition has caused the submission of this claim.	
5. If curtailment was due to an injury or illness suffered by an individual appearing on the certificate of insurance and who travelled on the holiday, please provide the written confirmation of the physician who treated the individual in resort that curtailment was medically necessary.	
6. If curtailment is due to a death we require a certified copy of the death certificate. In addition if the deceased was insured under the certificate upon which this claim is being submitted we require a copy of the grant of probate/letters of administration issued in respect of the deceased's estate.	
7. If this claim is being submitted as a result of an injury please provide a full description of the incident leading to the injury, if a third party was involved please provide their details and those of their insurer if available.	
8. If curtailment is for a reason other than those detailed in points 4, 5, 6 and 7 please forward independent written evidence of the incident or circumstances that have resulted in the submission of the claim.	

When we receive your claim submission, we will assess it and correspond with you further in due course.

We look forward to hearing from you.

Yours faithfully,

**Claims Department**

# Travel Insurance Claim Form.

Travel Claims Department  
 PO Box 60108, London, SW20 8US  
 Date  Claim

**UK\_USD AIRA**

Please answer all the questions contained in this claim form, leaving items blank, using ticks, dashes and N/A may make it necessary for us to return your claim forms or lead to us asking unnecessary questions thus delaying the processing of your claim.

Mr/Mrs/Miss/Ms	<input type="text"/>		<b>Personal Details - Required for all Claims</b>	
Surname	<input type="text"/>		Home Address	<input type="text"/>
Forenames	<input type="text"/>			<input type="text"/>
Date of Birth	<input type="text"/>	<input type="text"/>		<input type="text"/>
Occupation	<input type="text"/>		Postcode	<input type="text"/>
National Ins No.	<input type="text"/>		Home Tel.	<input type="text"/>
Nationality	<input type="text"/>		Email	<input type="text"/>
			Work Tel	<input type="text"/>

## Policy and Holiday Details

Policy Number	<input type="text"/>	
Date Issued	<input type="text"/>	
Travel Booking Reference	<input type="text"/>	
Travel Agent / Tour Operator	<input type="text"/>	
Date of Booking Holiday	<input type="text"/>	No. in Party <input type="text"/>
Depart Date	<input type="text"/>	Return Date <input type="text"/>
Total Days	<input type="text"/>	
Destination Country	<input type="text"/>	

## Type and Amount of Claim

Policy Benefit	Amount Claimed	Policy Benefit	Amount Claimed
Cancellation or Curtailment	<input type="text"/>	Loss of Passport	<input type="text"/>
Medical Expenses	<input type="text"/>	Hijack	<input type="text"/>
Hospital Benefit	<input type="text"/>	<b>Additional Options</b>	
Mugging Benefit	<input type="text"/>	Ski Equipment	<input type="text"/>
Personal Accident	<input type="text"/>	Ski Hire	<input type="text"/>
Personal Belongings	<input type="text"/>	Ski Pack	<input type="text"/>
Personal Money	<input type="text"/>	Piste Closure	<input type="text"/>
Personal Public Liability	<input type="text"/>	Other	<input type="text"/>
Travel Delay	<input type="text"/>	<b>Total Amount Claimed</b>	<input type="text"/>
Missed Departure	<input type="text"/>		
Legal Expenses	<input type="text"/>		

## Please complete this section if you wish us to pay any approved settlement to your Bank Account.

Account Holder	<input type="text"/>
Name of Bank	<input type="text"/>
Account No.	<input type="text"/>
SWIFT Code	<input type="text"/>

### How we use your information

Information which you supply to us, including sensitive information relating to health or medical condition, may be used in a number of ways, for example:

- to assess and process your claim
- to prevent crime (including fraud and money laundering)
- for audit, record keeping, statistical analysis and optional customer satisfaction surveys
- to comply with any legal requirement on us or other companies in our group
- to make decisions about you and other people when selling insurance

We may share information with our contractors (including service providers), agents and other international group companies for these purposes. Information may be put on a register of claims and shared with other companies, including insurers, for fraud prevention. We will share information with other third parties if required to do so by law.

We may transfer your information outside of the European Economic Area ("EEA") for the above purposes, including for secure electronic storage. Whenever we transfer or share information outside, or inside, the EEA we ensure that it is protected.

If you give information to us about another person, you will obtain that person's permission beforehand to provide the information and for us to use it as described above.

## CLAIMS DECLARATION

- I / WE GIVE PERMISSION FOR MY / OUR PERSONAL INFORMATION TO BE USED AND SHARED IN THE WAYS DESCRIBED ABOVE.
- I / WE CONFIRM THAT I / WE WILL NOT PROVIDE ANY PERSONAL INFORMATION ABOUT ANOTHER PERSON WITHOUT THAT PERSON'S PERMISSION, AND THAT WHERE A CLAIM IS MADE ON BEHALF OF THAT PERSON, I / WE HAVE THEIR EXPLICIT AUTHORITY TO ACT AND RECEIVE ANY PAYMENT ON THEIR BEHALF.
- I / we declare that all the information given in respect of the claim(s) is to the best of my / our knowledge and belief, full, true and correct, and that no material information has been omitted which would affect the assessment of the claim(s) by the insurer(s).
- I / we understand that if I / we give information that is incorrect or incomplete you and / or the insurer(s) may take action against me / us, including court action.
- I / we know it is a CRIMINAL offence to defraud, or attempt to defraud an insurer and that by doing so I / we may be prosecuted.
- I / we give my / our authority to you to contact my / our household insurers, medical insurers, DSS or other insurers / third parties regarding a contribution.

**I / we have read and fully understand the declarations above (ALL persons claiming must sign below).**

Claimants Name	Claimants Signature	Date of Birth	Dated
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**Reason for Curtailment - Please Tick ONE Box Only**

<b>Death</b> <input type="checkbox"/>	<b>Illness</b> <input type="checkbox"/>	<b>Injury</b> <input type="checkbox"/>	<b>Non Medical</b> <input type="checkbox"/>
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**Documents You Need to Send Us - SEND ORIGINAL DOCUMENTS BUT PLEASE KEEP COPIES FOR YOUR RECORDS**

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|--|---|
| <p>1. Insurance policy schedule/certificate of insurance/tour operators booking invoice showing payment of your insurance premium.</p> <p>2. Original evidence to substantiate travel e.g booking invoice, travel itinerary, tickets, Insurance Certificate / Document.</p> <p>3. All unused and used travel tickets, itineraries etc</p> <p>4. If curtailment is due to the medical condition, including death, of someone in the UK please have the attached medical certificate completed by the usual medical practitioner of the individual whose condition has caused the submission of this claim.</p> <p>5. If curtailment was due to an injury or illness suffered by an individual appearing on the certificate of insurance and who travelled on the holiday, please provide the written confirmation of the physician who treated the individual in resort that curtailment was medically necessary.</p> | <p>6. If curtailment is due to a death we require a certified copy of the death certificate. In addition if the deceased was insured under the certificate upon which this claim is being submitted we require a copy of the Grant of Probate/Letters of Administration issued in respect of the deceased's estate.</p> <p>7. If this claim is being submitted as a result of an injury please provide a full description of the incident leading to the injury, if a third party was involved please provide their details and those of their insurer if available.</p> <p>8. If curtailment is for a reason other than those detailed in points 3 and 4 please forward independent written evidence of the incident or circumstances that have resulted in the submission of the claim.</p> |
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**If you are unable to supply any of the documentation requested please provide a written explanation as to why.**

**Please answer ALL Questions Below - BLOCK CAPITALS PLEASE**

**1. Dates of scheduled return and actual return.**

Scheduled return date:	/ /	No. of nights booked	
Actual return date:	/ /	No. of nights not used	

**2. If curtailment was due to a person who was not travelling with you, please state their name and relationship to you.**

Name

Relationship

**3. Did your travel arrangements differ from your original booking?**

(a) Was any attempt made to revalidate or use your original tickets?

**YES**     **NO**

(b) If answer to (a) is YES, were you successful in your attempts?

**YES**     **NO**

(c) If answer to (a) is NO please have an explanation as to why no attempt was made to revalidate your tickets form part of your answer to question 6.

**6. Please detail the reasons for curtailment (continue on a separate sheet if necessary).**

**4. Names and ages of all those curtailing.**

Name	Date of Birth

**5. 24 Hour Emergency Service**

(a) Was the assistance company contacted?     **YES**     **NO**

If your answer to (a) is NO please explain why the assistance company was not contacted when completing Question 6.

(c) Date and time of first call.

/ /	
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(d) Name of person spoken to.

(e) Reference number given.

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**7. Other Insurance**

a. Are the expenses insured by any other policy you have? e.g Travel Agent issued or credit card policy.

YES	NO
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NB (A contribution payment is normal practice where 2 policies cover the same loss, this will not affect any no claims discount on that policy)

b. If yes, please supply the following details:

Company Name and Address	
Policy No	

**8. Payment of Trip**

a. Did you pay for all or part of the trip by credit card?

YES	NO
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b. If yes, please provide the following information:

Name of Card:		Cardholder name:	
Name of Card Issuer (if different):			

**Access to Medical Records Act, 1988/Access to Personal Files and Medical Reports. (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993. (Isle of Man) ("The Acts")**

To enable Travel Guard EMEA Limited to assess your claim, it may be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to the Acts. (Please note that Reports requested from Doctors appointed by Travel Guard EMEA Limited are not subject to the Acts). In summary your statutory rights are as follows.

1. A Medical Report cannot be requested from any doctor who has attended you, without your written authority.
2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is supplied. If you do not give consent we may be unable to proceed with your claim.
3. If you say you wish to see the report, we will write to your doctor and tell them, and advise you that we have done so. You will then have 21 days from the date of notification to contact the doctor to make arrangements for you to see the report.
4. The medical practitioner will be informed that you wish to have access to the report and will allow 21 days from the date of the notification for you to see and approve it before it is supplied to us. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made he/she will assume that you do not wish to see the report and that you consent to it being supplied.
5. If you say that you do not wish to see the report, we do not have to notify you if we apply for one.
6. Whether or not you say you wish to see the report before it is sent to us, you may ask your doctor to show you a copy of the report for up to 6 months after it is supplied. The practitioner may charge a reasonable fee for the cost of supplying a report not exceeding £50.
7. If you see a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor, asking that any part of the report which you consider to be incorrect or misleading be amended and to have attached to the report a statement of your views on any part where you and the doctor are not in agreement.
8. The doctor is not obliged to let you see any part of a report if,
  - a) In his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others.
  - b) It would indicate the doctor's intentions towards you.
  - c) Disclosure would be likely to reveal information relating to, or the identity of, someone else that has supplied information about you, unless that person has consented.

Your Regular GP:		Telephone:	
Address:		Fax:	

DECLARATION. I DECLARE THAT ALL THE INFORMATION GIVEN IS TO THE BEST OF MY KNOWLEDGE AND BELIEF, FULL, TRUE AND CORRECT, AND I UNDERSTAND THAT IF I GIVE INFORMATION THAT IS INCORRECT OR INCOMPLETE YOU MAY TAKE ACTION AGAINST ME, INCLUDING COURT ACTION.

I GIVE PERMISSION FOR MY PERSONAL INFORMATION TO BE USED AND SHARED IN THE WAYS DESCRIBED ABOVE. I CONFIRM THAT I WILL NOT PROVIDE ANY PERSONAL INFORMATION ABOUT ANOTHER PERSON WITHOUT THAT PERSON'S PERMISSION

<input type="checkbox"/>	I DO NOT wish to see the records before they are sent to Travel Guard EMEA Limited.
<input type="checkbox"/>	I DO wish to see the records before they are sent to Travel Guard EMEA Limited.

Patients Signature	
Full Name	

Date:	
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# Medical Certificate

Claim Ref:

This form is to be completed by the registered General Practitioner (GP) of the person whose illness/injury/death has caused the claim.

**Note** - Any charge made for its completion is the responsibility of the patient or claimant.

- Please answer all questions. Ticks, dashes, N/A are not acceptable. Please complete in CAPITALS.
- All information is treated as Private and Confidential.

Name of the patient:

Date of Birth:  How long have you been the patients GP?

Give full description of illness or injury that caused the cancellation:

Onset date of symptoms:  Date first consulted:  Date of diagnosis:

In date order, please advise any previous medical history relevant to the above condition.

At the time that the insurance was purchased, was the person receiving, or on a waiting list for, or recovering from in-patient treatment in a hospital/nursing home:  YES  NO

If YES, Please provide details:

At the time the journey was booked was the patient

On a hospital waiting list?	YES	NO	<input type="text"/>
Taking any medication	YES	NO	<input type="text"/>
Undergoing any tests or waiting for results of any test	YES	NO	<input type="text"/>
Aware of the condition?	YES	NO	<input type="text"/>
Given a terminal diagnosis?	YES	NO	<input type="text"/>

In your opinion and in accordance to the patients medical history

What date did it became apparent that the travel arrangements should be cancelled:

What date did you advise there was a need to cancel the travel arrangements:

When would they be fit to travel again:

(ii) has the patient been signed off work:  YES  NO From  To

Please provide the patient's state of health at the time the holiday was purchased:

Was the patients medical condition stable and under control at the time of booking?  YES  NO

## GP DECLARATION

I have examined the patient and/or referred to their medical records and declare that the information given is correct and no relevant details have been withheld.

GP Name:	Surgery Stamp
Contact number:	
GP Signature:	
Date Signed:	