

Claims International Limited

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(calls may be monitored or recorded for quality purposes)

REGISTERED IN ENGLAND NO: 2134239 REGISTERED OFFICE: 14TH FLOOR, LEON HOUSE, 201-241 HIGH STREET, CROYDON

IMPORTANT

Please keep a separate note of this claim reference number and quote it whenever you contact us.

Date:

Dear

HOLIDAY/TRIP CANCELLATION FORM

Here is your claim form as requested. Please complete it fully and return to us.

Please check that we have correctly stated your name, initial(s), address and post code and amend if necessary.

Our aim is to give you the fastest possible service but to achieve this, we need you to answer **ALL** the questions in detail and to submit documents in support of the claim.

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form. Thank you.

VERY IMPORTANT

Please ensure you enclose the following **ORIGINAL** (not photocopied) documents (if not already sent).

- | | | | | | | | |
|----|---|--------------------------|--------------------------|----|---|--------------------------|--------------------------|
| a) | Proof of insurance, such as the numbered certificate or validation receipt or tour operators invoice showing insurance. | Yes | No | b) | The holiday booking invoice or other evidence of holiday/trip cost and dates. | Yes | No |
| | | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |

Evidence of cancellation charges.

- | | | | |
|----|---|--------------------------|--------------------------|
| c) | Either:
For all inclusive tours (package holidays) organised by a Tour Operator you must attach the Tour Operator's cancellation invoice showing cancellation charges levied and any refund made. | Yes | No |
| | | <input type="checkbox"/> | <input type="checkbox"/> |

or

- | | | |
|--|--------------------------|--------------------------|
| For independently booked holidays (or journeys) you must submit the unused travel tickets (or vouchers) together with official confirmation of the cancellation charges levied and any refunds made from the Airline/Ferry Company/Coach Company/ Hotel. | Yes | No |
| | <input type="checkbox"/> | <input type="checkbox"/> |

CLAIM FORM NOTES RELATING TO MEDICAL CANCELLATION.

If the cancellation is due to medical reasons please ensure the medical certificate on this claim form is fully completed by the patient's doctor. Failure to have the medical certificate completed will delay the processing of your claim. In the event of cancellation because of bereavement a copy of the Death Certificate will also be required.

TELECLAIMS

If you have no objection, in an effort to promote speedier and more customer-friendly claims handling we may find it easier to telephone you during the course of our normal working hours to discuss your claim and/or request further details. Please advise us of any relevant numbers on which you can be reached.

or

IF COMPLETING BY HAND BLOCK CAPITALS MUST BE USED PLEASE

1. Claimant's title: If Other, please specify:
Forenames:
Surname:

2. Address:

Post Code:

3. Telephone No. Daytime:
 Evening:

4. Occupation: Age:

5. The destination and country of this holiday/trip:

6. a. The date the insurance policy was issued (this is important):
 DAY: MONTH: YEAR:

b. The certificate no. and prefix:
 PREFIX: NO:

7. The name of the travel agent who issued the insurance:

8. The period of your holiday/trip giving total number of days.
From: To:
Total no. of days:

9. No. of people covered by this policy:

10. The tour operator from whose brochure you booked (if relevant):

11. The day on which your holiday/trip was first booked:
 DAY: MONTH: YEAR:

12. a) Please advise the date on which you either decided or were advised to cancel: DAY: MONTH: YEAR:

b) Please advise the date on which you gave cancellation instructions either: DAY: MONTH: YEAR:

i) Verbally (including telephone) ii) Written (including fax)

c) If the dates provided in 12(a) and 12(b) differ, please explain reason:

13. Please describe the exact circumstances which have caused you to cancel the holiday. If the reason for cancellation is not of a medical nature we will require suitable documentary evidence to support the claim.

14. Please list all persons cancelling this trip who are insured by the policy and give their relationship to the person to whom the medical certificate applies, Include the name of the person whose illness/injury caused the cancellation if he/she was travelling with you.

	NAME	RELATIONSHIP	AGE
1.			
2.			
3.			
4.			
5.			
6.			

15. Was the person named on the medical certificate due to travel on this holiday/trip? YES NO

16. Should we require further medical information, it would help us to be able to contact the GP/attending specialist ourselves.

Does the patient agree to this? Yes No

Patient's name (printed)

Signed (by patient)

Dated

MEDICAL CERTIFICATE

The following medical certificate must be completed by the patient's usual GP or attending specialist.

Dear Medical Practitioner,

To avoid delay and unnecessary correspondence please complete this certificate answering each question as fully as possible.

Any fee for completing this certificate is the responsibility of the patient/claimant. Thank you

NOTE: PLEASE COMPLETE IN BLOCK CAPITALS

17.	Name of person for whom these details apply:		
18.	How long have you been the Patient's GP?		
19.	Age and date of birth:		
20.	Relationship to claimant (if known):		
21.	When did the patient first consult you with regard to this condition and please give date and time of diagnosis? Date first consulted Date and time of diagnosis		
22.	(a) Please state exact nature of the illness/injury which made cancellation of the holiday/trip medically necessary and prevents travel:		
	(b)	Has the patient received a terminal prognosis?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(c)	Details of any previous medical history relevant to the above condition:	
	(d)	Was the patient under any treatment or receiving medication (relevant to the above condition)	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details:
	(e)	Was the patient on a hospital waiting list for treatment for the condition which caused cancellation?	Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details and dates:
23.	If cancellation has occurred due to a pregnancy related condition please describe the condition and why the pregnancy necessitates cancellation: a) Date pregnancy confirmed: b) E.D.D.:		
24.	Were you aware of the holiday plans when you were first consulted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
25.	Please confirm the date that cancellation could have been reasonably anticipated:		
26.	Was the patient due to travel on the cancelled trip?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If yes	a) Was the patient fit to travel on the date the policy was issued? Please refer to question 6a) opposite before answering this.	Yes <input type="checkbox"/> No <input type="checkbox"/>
		b) Was the patient travelling contrary to medical advice?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If no	c) What was the patient's state of health on the date the insurance policy was issued? Please refer to question 6a) opposite before answering this.	

I CERTIFY THAT THE REASON FOR CANCELLATION WAS DUE ONLY TO THE MEDICAL REASONS STATED ABOVE.

Name (print)
Signature
Qualifications
Date

Name and Practice Address (official stamp)
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27. **Failure to provide this information could delay your claim**
 Certain household contents policies provide an element of travel cover. Do you have a household contents insurance policy or if you are living with your parents do they have a policy? Yes No
 If yes, please supply the name and address of the insurance company and policy number.
 Name:
 Branch Address:
 Policy No:

28. Do you have any other insurance which may cover this incident? Yes No
 If yes, please supply details of the policy(ies):

29. Was a credit card used to pay all or part of the holiday/trip cost? Yes No
 If yes, please supply the following information:
 Name of card: Cardholders name:
 Name of card issuer: Credit card no:
 (if different)

Please detail below the amount of the claim (excluding insurance premiums)

INDEPENDENT ARRANGEMENTS

PACKAGE TRIPS ONLY

Travel Ticket Cost	£	Date Paid:
Amount Refunded	£	
NETT CLAIM	£	
Accommodation cost/or other	£	Date paid:
Amount Refunded	£	
NETT CLAIM	£	
Total amount Claimed	£	

Deposit Paid	£	Date Paid:
Balance Paid	£	Date Paid:
Total	£	
Deduct Refund Received	£	
Total amount Claimed	£	

FOR OFFICE USE ONLY	FOR OFFICE USE ONLY	
TOTAL £	TOTA X/S £	TOTAL NETT £

IMPORTANT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION
 Please note neither we nor insurers are responsible for the costs of obtaining documentation in support of the claim.
 May we suggest you keep copies of all documentation for ease of reference.

WARNING

THE MAKING OF A FRAUDULENT OR KNOWINGLY EXAGGERATED CLAIM IS A CRIMINAL OFFENCE AND COULD RENDER THE OFFENDER LIABLE TO PROSECUTION.

THE INFORMATION ON THIS FORM WILL BE USED BY YOUR INSURER TO DEAL WITH ANY CLAIM. YOUR INSURER MAY ALSO PASS THIS AND ANY OTHER INFORMATION TO OTHER INSURERS AND OGRANISATIONS INVOLVED IN DEALING WITH ANY CLAIM. INSURERS ALSO SHARE INFORMATION TO PREVENT FRAUD.

DECLARATION:

I/We declare that the information contained within this claim form is true and correct to the best of my/our knowledge and belief.
 I/We have not withheld any information or documentation from insurers within my/our knowledge connected with this claim.
 I/We agree to provide further information or documentation as may be reasonably required.
 I assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever else is necessary to secure such rights.

SIGNATURE OF CLAIMANT: DATE: