

TRAVEL ACCIDENT INSURANCE

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 it 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.

b) the holiday booking invoice or other evidence of holiday / trip cost.

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.

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.

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 would also be appreciated.

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 (8am - 6pm) to discuss your claim and/or request further details. Please advise us of any relevant numbers on which you can be reached:

or

BLOCK CAPITALS MUST BE USED PLEASE

OFFICE USE ONLY

<p>1. Claimant's title: MR / MRS / MISS / MS. Forenames: _____ Surname: _____</p> <p>2. Address: _____ _____ _____ Post Code: _____</p> <p>3. Telephone No. Daytime: _____ Evening: _____</p> <p>4. Occupation: _____ Age: _____</p> <p>5. The destination and country of this holiday/trip: _____</p>	<p>6. a. The date of policy issued (this is important): DAY: _____ MONTH: _____ YEAR: _____</p> <p>b. The certificate no and prefix: PREFIX: _____ NO: _____</p> <p>7. a. What date did you advise that cancellation of the holiday was necessary? b. No. of people insured by this policy: _____</p> <p>8. The tour operator from whose brochure you booked (if relevant): _____</p> <p>9. The day on which your holiday/trip was first booked: DAY: _____ MONTH: _____ YEAR: _____</p>																												
<p>10. 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) <input type="checkbox"/> ii) Written (including fax). <input type="checkbox"/> c) If the dates provided in 10(a) and 10(b) differ, please explain reason: _____ _____ _____</p>																													
<p>11. 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 documentary evidence to support the claim. _____ _____ _____</p>																													
<table style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="width: 35%;"></th> <th style="width: 25%;">NAME</th> <th style="width: 25%;">RELATIONSHIP</th> <th style="width: 15%;">AGE</th> </tr> </thead> <tbody> <tr> <td style="vertical-align: top;">12. Please list all persons canceling 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.</td> <td>1. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td></td> <td>2. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td></td> <td>3. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td></td> <td>4. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td></td> <td>5. _____</td> <td>_____</td> <td>_____</td> </tr> <tr> <td></td> <td>6. _____</td> <td>_____</td> <td>_____</td> </tr> </tbody> </table>			NAME	RELATIONSHIP	AGE	12. Please list all persons canceling 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.	1. _____	_____	_____		2. _____	_____	_____		3. _____	_____	_____		4. _____	_____	_____		5. _____	_____	_____		6. _____	_____	_____
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	4. _____	_____	_____																										
	5. _____	_____	_____																										
	6. _____	_____	_____																										
<p>13. Was the person named on the medical certificate due to travel on this holiday/trip? YES <input type="checkbox"/> NO <input type="checkbox"/></p>																													

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 (in block capitals),

Answering each question as fully as possible.

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

1. Name of person for whom these details apply : _____
2. Age and date of birth : _____
3. Relationship to claimant (if known) : _____
4. 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 _____
5. (a) Please state exact nature of the illness/injury which made cancellation of the holiday/trip medically necessary and prevents travel:

- (b) Detail of any previous medical history relevant to the above condition:

- (c) Was the patient under treatment or receiving medication? If yes please provide details.

- (d) Was the patient on a hospital waiting list for treatment for the condition which caused cancellation?
 If yes please provide details and dates:

6. If cancellation has occurred due to a pregnancy related condition please describe the condition:

- a) Date pregnancy confirmed _____ b) E.D.D.: _____
7. Were you aware of the holiday plans when you were first consulted? YES NO
8. If you were not aware of the holiday plans please confirm the date that cancellation could have been reasonably anticipated: _____
9. a) In your professional opinion was the patient fit to travel on the date the travel insurance/holiday was booked?

I CERTIFY THAT I ADVISED CANCELLATION SOLELY DUE TO THE MEDICAL REASONS STATED ABOVE.

Signature _____

Qualifications _____

Date _____

Name and Practice Address (official stamp)

Do you have a travel extension to a private medical Insurance scheme other than RSA Medical Scheme? If so, please provide details so we may check any Duplicate insurance cover for you. YES <input type="checkbox"/> NO <input type="checkbox"/>	Name: _____
	Address: _____

	Policy/Membership No: _____

Where a credit card has been used to pay all or part of the holiday/trip cost, please supply the following information:	
Name of card: _____	Cardholders name: _____
Name of care issuer: _____	(if different)
Credit card no: _____	

Please detail below the amount of the claim

INDEPENDENT ARRANGEMENTS

PACKAGE TRIPS ONLY

(excluding insurance premiums)

Ticket cost _____ Date paid: _____ Amount _____ Date paid: _____ refunded Accommodation _____ Date paid: _____ cost/or other Amount Refunded : _____ Total amount Claimed : _____	Deposits paid: _____ Date paid: _____ Balance paid: _____ Date paid: _____ Total: _____ Date paid: _____ Deduct Refund Received : _____ Total amount Claimed : _____
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FOR OFFICE USE ONLY		
TOTAL.	TOTAL X/S.	TOTAL NETT.

We believe our policyholders are honest. This contract is based upon mutual trust between us, however, fraudulent claims are occasionally made.

Where fraud (which can include exaggerated claims) is detected the claim will not be paid. The policy will be rendered invalid and we may refer the matter to the police or take other legal action.

IMPORTANT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION

Prior to returning the claim form please study the IAG Travel Service policy wording and read the terms and conditions as they relate to your claim.

Please note neither we nor insurers are responsible for the costs of obtaining documentation in support of the claim.

DECLARATION:

I/We declare that to 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 any further information or documentation as may be reasonably required.

I subrogate and assign to insurers all rights of recovery / salvage against any person or organization and will do whatever else is necessary to secure such rights.

SIGNATURE OF CLAIMANT: _____ DATE: _____