CANCELLATION CLAIM FORM

Claim Number: A claim number will be allocated once this form is returned

Claims Settlement Agencies Limited
308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD
Tel: 0844 8262644 Fax: 0844 8262645
email: info@csal.co.uk www.csal.co.uk

Date:

Please use the above address for ALL correspondence & quote the above Claim Number in ALL subsequent communication.

When the Claim Form is received we aim to process it in five working days.

This claim form is being provided to you as requested in order that you can make a claim for Cancellation under the terms and conditions of your travel insurance policy.

Below is a Document Check List – please ensure you provide the correct documentation when submitting your claim as failure to do so may cause delays.

We suggest you keep a copy of this claim form and other documents for your own records.

IMPORTANT DOCUMENT CHECK LIST Have you enclosed or previously provided the following **ORIGINAL** (not photocopy) documents?	✓ **PLEASE TICK**			
	Enclosed	**Previously Sent**	**Not Available**	**Not Applicable**
CERTIFICATE OF INSURANCE (or other proof of payment of insurance premium i.e. the Tour Operators booking invoice)				
HOLIDAY BOOKING INVOICE as issued by the booking Agent & Tour Operator				
PACKAGE TRIPS ONLY - please enclose the **TOUR OPERATORS CANCELLATION INVOICE** showing the cancellation charges levied and any refund due				
INDEPENDENT ARRANGEMENTS ONLY - please submit either; **Confirmation of the amount paid and refunded from the Travel Agents / Airline / Apartment Owners / Other** Or **The unused tickets together with official written confirmation that no refund is available**				
MEDICAL CANCELLATION please ensure that the **MEDICAL CERTIFICATE on page 3 of the claim form** is completed by the patient's normal General Practitioner. If you submit a private certificate it may not contain the information we require and delays are likely to arise as a result. All information requested in our medical certificate is IMPORTANT Please also ensure the **CONSENT TO OBTAIN A MEDICAL REPORT on page 3 of the claim form is completed** by the patient OR next of kin				
NON MEDICAL CANCELLATION - please submit **documentary evidence to support your claim**				

PLEASE ANSWER ALL QUESTIONS IN BLOCK CAPITALS – THANK YOU FOR YOUR CO-OPERATION

CLAIMANT DETAILS

Q01. Claimant's Details: Title: First Names: Surname:

Q02. Date of Birth: / / Present Age: **Q03.** Occupation:

Q04. Address:

Post Code:

Q05. Home Tel: Mob Tel: Work Tel:

E-mail:

HOLIDAY & INSURANCE DETAILS

Q06. Holiday booking date: / / Period from: / / to: / / Number of days:

Q07. Number of people in your party: **Q08.** Holiday Country & Destination:

Q09. Name of the travel agent who issued the policy:

Q10. Travel Insurance Policy Number (as shown on your insurance schedule):

Registered in England Number: 02558156 Registered Address: 72 New Cavendish Street, London, W1M 8AU

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Q11. Policy issue Date ***(very important)***: / /

Q12. Method of payment for the holiday (Delete as necessary): Credit Card / Debit Card / Cheque / Cash/ Other

If credit card was used please provide details: Card Issuing Company:

CLAIM DETAILS

Q13. Kindly list all persons cancelling the trip that are insured by this policy and if due to medical reasons give their relationship to the person named on the medical certificate overleaf (list on additional sheet if necessary)

Insured Name	Age	Relationship to Patient
1.		
2.		
3.		
4.		

Q14. Cancellation date: a. Verbally (if applicable) Date: / / b. In Writing Date: / /

Q15. If the cancellation was due to medical reasons or death, please give details below and ***arrange for the medical certificate on page 3 of this form to be completed*** by the normal General Practitioner of the person whose medical condition has caused the cancellation of the holiday/trip.
Medical Reasons:

Q16. Was the person named in the Medical Certificate on page 3 due to travel on this trip (Delete as necessary)? **YES / NO**

Q17. If the cancellation was for non-medical reasons covered by the policy please provide documentary evidence to support the claim (it may be necessary to correspond further) Non-medical Reasons:

Q18. Please detail below the amount of the claim

INDEPENDENT ARRANGEMENTS	£	PACKAGE TRIPS ONLY	£
Cost of Tickets		Total cost of holiday	
Cost of accommodation		Deduct insurance premiums	
Deduct refunds received or advised		Deduct refunds received or advised	
Final amount claimed before excess		**Final amount claimed before excess**	

OTHER INSURANCE & PREVIOUS CLAIMS

Q19. Do you have any other insurance that covers the expenses you are claiming **YES / NO** If 'YES' please provide the full details of the policy holder (if different to claimant), the company name/address and policy number: Name of Policy Holder:

Company Name & Address: Policy Number:

Q20. Has this claim been submitted (or will it be) to the other insurer or to any other party? **YES / NO** Their ref (if known):

Q21. Have you or any other person named on this form ever made any previous claims on this type of insurance **YES / NO** If YES please give details *(Please continue on a separate sheet if necessary):*

DATA PROTECTION NOTICE

Claims Settlement Agencies Ltd may use your information together with other information for underwriting, statistical analysis and claims. We may disclose your information to our service providers, agents and business partners for these purposes.

We may also share your information with other interested parties and outside agencies to check the details and prevent fraudulent claims. We may also disclose your information to our agents to investigate or prevent fraud.

CUSTOMER DECLARATION – To Be Completed By ALL Persons Claiming Aged Over 16

Claims Settlement Agencies Ltd, agents and business partners may contact anyone who can give them information relevant to my claim. I/ We confirm that the information that I/ we give is true and if any of the information given by me/ us (or anyone on my/ our behalf) is incorrect, I/ we agree that such inaccuracy may cause me/ us to forfeit my/ our rights under the policy.

In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.

Payments: Subject to admission of liability, we will make payment in favour of the claimant (aged over 16) as detailed in question **Q01** above but if an alternative payee is required please state below. I/ We have read and fully understood the above declaration.

Insured Name	Signature	Date of Birth	Date of Signature

ACCESS TO MEDICAL REPORTS ACT 1988

You are responsible for arranging completion of the Medical Certificate on page 3 of the claim form. However, if on receipt of that Medical Certificate it is deemed necessary to obtain a further medical report from the doctor concerned in relation to this claim we will obtain further information from the doctor ourselves. In that event, before we can write to the doctor we require consent from the patient or next of kin as appropriate. Before signing the consent form, the patient concerned should read the following summary of their rights under the Access to Medical Reports Act 1988;

a) You can withhold your permission but if you do we will be unable to proceed with your claim if further information is required
b) If you wish to see the medical report, you must indicate on the claim form and contact your doctor within 21 days about arrangements to see the report. Whether or not you wish to see the report before it is sent to us, the doctor must let you see a copy for up to 6 months after it is supplied, if you ask
c) You can ask the doctor if he/she will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement you may append your comments

Your doctor can in certain circumstances withhold the report from you, or any part of it.

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CONSENT TO OBTAIN A MEDICAL REPORT TO BE COMPLETED BY THE PATIENT OR NEXT OF KIN (AS APPROPRIATE)

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

Patient Name: Signed (Patient): Date: / /

Doctor's Name: Address:

MEDICAL CERTIFICATE

TO BE COMPLETED BY THE PATIENT'S GENERAL PRACTITIONER AT THE EXPENSE OF THE CLAIMANT

Note: The patient is the person whose medical condition has caused the cancellation of the holiday/trip and does not have to be a member of the travelling party. To avoid delays please complete this certificate in FULL and in BLOCK CAPITALS and answer each question as fully as possible. Thank you for your co-operation.

01. Name of the patient: Date of birth: / /

02. Relationship to claimant named in question Q01 on page 1 of the claim form (if not the claimant):

03. Please state the nature of the illness/injury that makes cancellation of the trip medically necessary and prevents travel:

04. When did the patient first consult you with regard to this condition and please give date and time of diagnosis

Date: / / Time: am/pm

05. Is there a previous history of the above condition or other relevant conditions? **YES / NO** If YES then please advise;

a. details: _____

b. date of onset: Date: ____ / ____ / _____ Diagnosis Date (if different): Date: ____ / ____ / _____

c. has the patient been under regular medical review for the condition(s) **YES / NO** If YES since when? Date: ____ / ____ / _____

d. is the patient on regular medication for the condition(s) **YES / NO** If YES date first prescribed: Date: ____ / ____ / _____

06. At the date the policy was effected (please refer to question **Q11.** overleaf for the date) or at any time during the 12 months prior to that date was the patient;

a. receiving in-patient treatment **YES / NO** If YES please give date: ____ / ____ / _____

b. on a waiting list for treatment **YES / NO** If YES please give date: ____ / ____ / _____

c. aware of a Terminal Prognosis **YES / NO** If YES please give date: ____ / ____ / _____

07. At the date the policy was effected (same date applies as per Q06 above) was the patient;

☐ Fit to travel ☐ Not Fit to travel ☐ Doubtful ☐ Not applicable as the Patient was not a member of the travelling party

08. If relevant to the condition has the patient suffered from any previously diagnosed psychiatric disorder **YES / NO**. If YES please give the cause of such condition:

09. What date did you advise the cancellation of the holiday necessary. Date: / /

10. If the cancellation is due to pregnancy please give;

a. Date of confinement: ____ / ____ / _____

b. Date pregnancy confirmed: ____ / ____ / _____

c. Date of LMP: ____ / ____ / _____

d. What illness/condition connected with the pregnancy gave rise to your recommendation not to travel?

11. Were you aware of the holiday plans when you were first consulted YES/ NO If No please confirm the date cancellation could reasonably have been anticipated: / /

12. If the patient was not travelling, could the travelling person(s) have foreseen or anticipated any possibility that the medical condition or related condition could have caused the cancellation of the trip either;

a. At the date the holiday was booked (see and insert date from question **Q06** on page 2 for date) / / **YES / NO**

b. At the date the insurance was taken out (see and insert date from question **Q11** on page 2 for date) / / **YES / NO**

If unsure, please give further details:

13. Can you certify the sole reason for cancellation was due only to the condition stated in question 03 above? **YES / NO**

Signature:

Qualifications:

Date: / /

Name & Address

Validation Stamp

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PAYEE'S BANK DETAILS					
IF WE APPROVE YOUR CLAIM, WE CAN CREDIT THE MONEY DIRECT TO YOUR BANK ACCOUNT. THIS METHOD IS QUICKER, SAFER AND MORE RELIABLE THAN PAYMENT BY CHEQUE. IF YOU WOULD LIKE US TO DO THIS, PLEASE COMPLETE THE FOLLOWING:					
Name of your Bank/Building Society:					
Bank Sort Code:					
Account Number:					
Name of Account Holder(s):					