Cancellation / Loss of Deposit Claim Form

Thank you for notifying us of your claim.
Please complete this claim form and return it to:

Specialty Claims Services
PO Box 51541
LONDON
SE1 0XU

If you need any help in completing this form please contact us on 0870 905 8555.

Claimant Details

Title	Full Name	Date of Birth	Occupation	Usual Country of Domicile

Claimant Address: ____

____

______________________ Postcode: ______________________

Telephone: ______________________ E-mail: ______________________

(E-mail may be used for correspondence if stated)

Insurance Details

Certificate Number: ____

Insurance Company: ____

Address of Broker: ____

Travel Details

Travel Destination: Country: ______________________

Resort: ______________________

Hotel: ______________________

Departure Date: ____/____/______ Return Date: ____/____/______

Purpose of Trip: ❑ Business ❑ Pleasure

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Claim Details

Reason for the Cancellation: ______________________________

If the reason for cancellation is medically related, the attached medical certificates ***must*** *be completed by the usual Doctor of the person whose condition caused the cancellation of the trip*

If the cancellation has been caused by a person not travelling and not insured on your policy, please state the relationship of that person to you: ______________________________

Date your insurance policy was purchased or renewed: ____/____/______

Period of Cover as stated on your travel insurance schedule: ____/____/______ to ____/____/______

Date you booked your trip: ____/____/______ Date you cancelled your trip: ____/____/______

Total deposit paid: £____________ Date paid: ____/____/______

Total balance paid: £____________ Date paid: ____/____/______

Total amount refunded: £____________ Date refunded: ____/____/______

Total amount claimed: £____________

Have you made any cancellation claims prior to this claim? ❑ Yes ❑ No

If yes, please give details: ______________________________

Do you hold any travel insurance with your current bank account? ❑ Yes ❑ No

If yes, please give details: ______________________________

Do you hold any travel insurance with the relevant tour operator? ❑ Yes ❑ No

If yes, please give details: ______________________________

Did you use your credit card to pay for all or part of your trip? ❑ Yes ❑ No

If yes, please provide the relevant card statement showing the transaction.

Have you submitted a claim to any other insurer/authority? ❑ Yes ❑ No

If yes, please give details: ______________________________

If your claim is agreed, please state to whom settlement should be made:

Print Payee Name: ______________________ Preferred Currency: ______________

Declaration

I declare that to the best of my knowledge all particulars contained in this form are true and correct. In the event of a third party being liable for loss/damage all rights in this matter are subrogated to Specialty Claims Services on settlement of the claim. If cover exists under any other policy, I give my authority for contribution to be sought from their insurers. I understand that some of the information provided will be made available to other insurers for underwriting or claims handling purposes.

Signed: ______________________________ Date: ____/____/______

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Guidance Notes

The following documentation must be provided in order for your claim to be processed.

Item	***Enclosed***
Your original booking invoice which is sent to you at the time of booking your trip If you have booked independent arrangements (i.e. car hire, airport hotel) then please provide us with a booking invoice for *each* item being claimed.	❑
Your original cancellation invoice which is sent to you at the time of cancelling your trip If you have booked independent arrangements (i.e. car hire, airport hotel) then please provide us with a cancellation invoice for *each* item being claimed.	❑
Your original travel insurance schedule showing the dates of cover and premium paid If you have an annual policy then a photocopy will be accepted.	❑
Evidence of necessity to cancel your trip: Medical – the attached medical certificate Redundancy – redundancy notice confirming eligibility for redundancy package Court Attendance – Court Subpoena	❑
Evidence of refund from tour operator/airline If you have booked scheduled flights, all air taxes must be claimed from the airline	❑
If you have submitted a claim to another insurance company, copies of all correspondence	❑

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Medical Certificate

To be completed by the **General Practitioner** of the person causing cancellation (whether travelling or not). Any charge made for the completion of this document is the responsibility of the Insured Person and is not refundable by the Insurers.

PLEASE NOTE: To avoid delay and unnecessary correspondence please complete this form in BLOCK CAPITALS and answer each question as fully as possible.

Question	Answer
1) Full name of the person to whom these medical details apply	
2) Date of birth and Age	DoB: / / Age:
3) Are you his/her usual general practitioner? If not, in what capacity are you involved?	❑ Yes ❑ No
4) Please state the exact nature of llness/accident which made cancellation necessary.	
5) Is there any previous medical history of the above condition or other relevant condition? If YES, please give details	❑ Yes ❑ No
6) When did the patient first consult you with regard to this condition?	Date: / /
7) When was the condition diagnosed?	Date: / /
8) When was cancellation deemed necessary?	Date: / /
9) Were you aware of the travel plans when first consulted? If NO, please confirm the first date on which cancellation could have been anticipated	❑ Yes ❑ No Date: / /
10) At the time the trip was booked, please state whether:	
(a) The condition was under control	❑ Yes ❑ No
(b) This was an exacerbation of any existing condition and if so the date of exacerbation	❑ Yes ❑ No Date: / /
(c) The patient was either on a waiting list for in-patient treatment or was an in-patient	❑ Yes ❑ No Date: / /
(d) The patient had received a terminal prognosis	❑ Yes ❑ No Date: / /
(e) If the patient was one of those travelling, the condition was a contra indication to do so	❑ Yes ❑ No
(f) Was travelling contrary to medical advice?	❑ Yes ❑ No
11) PREGNANCY ONLY	
(a) Date of LMP	Date: / /
(b) Date pregnancy confirmed	Date: / /
(c) Estimate date of confinement	Date: / /
(d) Exact medical condition preventing travel	

I certify that the cancellation was due solely to the medical conditions stated.	Practice Stamp
Name and Signature: ______________________	
Qualifications: ______________________	
Telephone Number: ______________________	