CANCELLATION CLAIM FORM

Claim Number:

HISCOX

308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD
T 0330 660 0752 E claims@hiscoxtravelinsurance.co.uk
www.hiscox.co.uk/travel

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. If original documents are being sent, we recommend sending via Recorded Delivery.

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 4 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 Name(s):	Surname:
Q02. Date of Birth: / /	Present Age:	
Q03. Occupation:		
Q04. Address:		
		Post Code:
Q05. Home Tel:	Mob Tel:	Work Tel:
Email:		

CANCELLATION CLAIM FORM

Claim Number:

HOLIDAY & INSURANCE DETAILS

Q06. Holiday booking date: / /	Period from: / /	Period to: / /	Number of days:
Q07. Number of people in your party:	Q08. Holiday Country & Destination:		

Q09. Name of Travel Insurance provider:

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

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 he 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:	Policy Number:
Company Name & Address:	
Q20. Has this claim been submitted (or will it be) to the other insurer/airline? **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 (continue on a separate sheet if necessary):

CANCELLATION CLAIM FORM

Claim Number:

DATA PROTECTION NOTICE

Personal Information – means information that identifies and relates to you or other individuals (i.e. your dependants). By providing **Personal Information** to Claims Settlement Agencies you give us permission for its use as described below. Full details about our use of **Personal Information** can be found in our full Privacy Notice at www.csal.co.uk/privacy-policy or you may request a copy using the contact details above.

When providing **Personal Information** about another individual to us, you confirm that you are authorised to provide it for use as described below.

Types of Personal Information we may collect and why:
Depending on our relationship with you, **Personal Information** collected may include:

- identification and contact information,
- payment card and bank account,
- credit reference and scoring information,
- sensitive information about health or medical condition,
- and other **Personal Information** provided by you.

Personal Information may be used for the following purposes:

- Insurance administration, (communications, claims processing and payment)
- Decision-making on provision of insurance cover and payment plan eligibility,
- Assistance and advice on medical and travel matters,
- Management and audit of our business operations,
- Prevention, detection and investigation of crime, (fraud and money laundering)
- Establishment and defence of our legal rights,
- Legal and regulatory compliance, including compliance with laws outside your country of residence,
- Monitoring and recording of telephone calls for quality, training and security purposes.

Sharing of Personal Information:
Personal Information may be shared with our group companies, Brokers and other distribution parties, Insurers and Reinsurers, Credit Reference Agencies, healthcare professionals and other service providers. **Personal Information** may be shared with other third parties (including government authorities) if required by law. **Personal information** (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

Security and retention of Personal Information:
Appropriate legal and security measures are used to protect **Personal Information**. All third party service providers are also selected carefully and required to use appropriate protective measures. **Personal Information** will be retained for the period necessary to fulfil the purposes described above.

International transfer:
Due to the nature of our business, **Personal Information** may be transferred to parties located in other countries with different data protection laws than in your country of residence.

Data requests:
To request access or correct inaccurate **Personal Information**, or to request the deletion or suppression of **Personal Information**, or object to its use, please e-mail: info@csal.co.uk and mark for the attention of the Data Controller, or write to Data Controller, 308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD.

DECLARATION I declare that the whole of the statements made and any other supplementary statements forming part of this claim are true in every respect and understand that a false declaration may invalidate my claim and could result in prosecution. 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.

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

Millstream Underwriting Ltd and Claims Settlement Agencies Ltd and their 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 01 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

CANCELLATION CLAIM FORM	Claim Number:	

ACCESS TO MEDICAL REPORTS ACT 1988

You are responsible for arranging completion of the Medical Certificate on page 4 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.

BANK ACCOUNT DETAILS

We may choose to settle your claim by electronic means. Therefore, please provide us with details of the bank account where you would like the funds to be paid.

Account Name:	Sort Code:	Account No:
(If outside UK) IBAN:	SWIFT:	

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 on following page…

CANCELLATION CLAIM FORM	Claim Number:	

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 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: / / Diagnosis date (if different): / /

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:	**Name & Address**
Qualifications:	Validation Stamp
Date: / /	