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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				
For curtailment due to illness/injury abroad please submit MEDICAL EVIDENCE from the treating doctor abroad confirming the curtailment was medically necessary				
For Curtailment due to death , please submit the DEATH CERTIFICATE and arrange for the General Practitioner of the person concerned to complete the MEDICAL CERTIFICATE on page 4 of this claim form				
For Curtailment due to injury or illness of a relative in the UK , please arrange for the normal General Practitioner of the person concerned to complete the MEDICAL CERTIFICATE on page 4 of this claim form death				
For Curtailment due to non-medical reasons , please provide DOCUMENTARY EVIDENCE of the necessity to return home early (please check the terms and conditions of your policy for specific coverage details)				
Details of and documents relating to original travel arrangements and any used/unused tickets				
Any other documentary evidence from which we can calculate your claim, which you feel is relevant.				

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.

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:		

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. The date the holiday was curtailed: Date: / /	Q15. Number of Nights lost:	
Q16. Please advise the reason for the curtailment of the trip - please give details below and provide the information as detailed in the DOCUMENT CHECK LIST on page 1 of this form Reason:		
Q17. If the curtailment was due to a medical condition of a member of the travelling party have you also made a MEDICAL claim? YES / NO		
Q18. Were the Assistance Company contacted YES / NO If 'YES' please provide name of company:		
Assistance Company Ref No (if known):	What type of assistance did they provide?	

Refund of Holiday/Trip Please note that Curtailment is calculated on a pro-rata basis			Details Of Any Other Expenses Incurred (continue on a separate sheet if necessary)	
Total Cost of Holiday/Trip (excluding Insurance Premiums and Surcharges)	Number of Nights Lost	Amount Claimed	Nature of Expense	Amount Claimed
Final Pro-Rata Claimed			Total Additional Expenses Claimed	

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:

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):

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

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.

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Patient Name:	Signed (Patient):	Date: / /
Doctor's Name:	Address:	

Medical Certificate on following page...

