

## CLAIMS INTERNATIONAL

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# HOLIDAY/TRIP CANCELLATION FORM

## WEB CLAIM

Dear Sir/Madam

Here is your claim form as requested. Please complete it fully and return to us.

**PLEASE ENSURE THAT YOU SIGN AND DATE THE FORM ON THE FINAL PAGE - FAILURE TO DO SO WILL DELAY YOUR CLAIM.**

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 or validation receipt or tour operator's invoice showing insurance. YES  NO
- (b) The holiday booking invoice or other evidence of holiday/trip cost and dates. YES  NO

### 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.

YES  NO

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.

YES  NO

### 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 will also be required.

## 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 our normal working hours to discuss your claim and/or request further details. Please confirm your email address overleaf and/or advise us of any relevant numbers on which you can be reached.



**CLEARBLOCK CAPITALS MUST BE USED PLEASE**

<b>1</b>	Claimant's title: Mr / Mrs / Miss / Ms / Other (please specify)		
	Forename(s)	Surname	
<b>2</b>	Address		
		Postcode	
<b>3</b>	Telephone daytime	Telephone evening	
<b>4</b>	E-mail address		
<b>5</b>	Occupation	Date of Birth	
<b>6</b>	The destination and country of this holiday/trip		
<b>7a</b>	The date the insurance policy was issued (this is important)	DAY:	MONTH: YEAR:
<b>7b</b>	The certificate number and prefix	PREFIX:	NO:
<b>8</b>	The name of the travel agent who issued the insurance		
<b>9</b>	The period of your holiday/trip giving total number of days	From:	To: Total Number of days:
<b>10</b>	The number of people covered by this policy		
<b>11</b>	The tour operator from whose brochure you booked (if relevant)		
<b>12</b>	The day on which your holiday/trip was first booked	DAY:	MONTH: YEAR:
<b>13a</b>	Please give the date on which you either decided or were advised to cancel	DAY:	MONTH: YEAR:
<b>13b</b>	Please advise the date on which you gave cancellation instructions either: <input type="checkbox"/> verbally (including telephone), or <input type="checkbox"/> in writing (including fax)	DAY:	MONTH: YEAR:
<b>13c</b>	If the dates provided in 13a and 13 b differ, please explain reason: ..... .....		
<b>14</b>	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 suitable documentary evidence to support the claim. ..... .....		
<b>15</b>	Please list all persons cancelling 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.		
	NAME	RELATIONSHIP	AGE
	1 .....	.....	.....
	2 .....	.....	.....
	3 .....	.....	.....
	4 .....	.....	.....
	5 .....	.....	.....
	6 .....	.....	.....
<b>16</b>	Was the person named on the medical certificate due to travel on this holiday trip? YES <input type="checkbox"/> NO <input type="checkbox"/>		

# 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, answering each question as fully as possible.

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

## NOTE: PLEASE COMPLETE IN BLOCK CAPITALS

<b>17</b> Name of person for whom these details apply
<b>18</b> How long have you been the Patient's GP?
<b>19</b> Patient's age and date of birth
<b>20</b> Relationship to claimant (if known)
<b>21</b> 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:.....
<b>22a</b> Please state exact nature of the illness/injury which made cancellation of the holiday/trip medically necessary and prevents travel: .....
<b>22b</b> Has the Patient received a terminal prognosis? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>22c</b> Details of any previous medical history relevant to the above condition .....
<b>22d</b> Was the patient under any treatment or receiving medication (relevant to the above condition) YES <input type="checkbox"/> NO <input type="checkbox"/> If YES, please provide details and dates: .....
<b>23</b> If cancellation has occurred due to a pregnancy-related condition please describe the condition and why the pregnancy necessitates cancellation: ..... a) Date pregnancy confirmed: ..... b) E.D.D.: .....
<b>24</b> Were you aware of the holiday plans when you were first consulted? YES <input type="checkbox"/> NO <input type="checkbox"/>
<b>25</b> Please confirm the date that cancellation could have been reasonably anticipated: .....
<b>26</b> Was the patient due to travel on the cancelled trip? YES <input type="checkbox"/> NO <input type="checkbox"/> If YES a) was the Patient fit to travel on the date the insurance policy was issued: YES <input type="checkbox"/> NO <input type="checkbox"/> Please refer to question 7(a) opposite before answering this. b) Was the Patient travelling contrary to medical advice? YES <input type="checkbox"/> NO <input type="checkbox"/> If NO c) What was the Patient's state of health on the date the insurance policy was issued? Please refer to question 7(a) opposite before answering this. .....

I CERTIFY THAT THE REASON FOR CANCELLATION WAS DUE ONLY TO THE MEDICAL REASONS STATED ABOVE.

Name (print) .....
Signature .....
Qualifications .....
.....
Date .....

Name and Practice Address (official stamp)
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