

# Cancellation Expenses Claim Form



Please complete this claim fully and return to us by following the postal instruction below.

Please return your completed form to:

Staysure Trip Cancellation Claims  
PO Box 9  
Mansfield  
Nottinghamshire  
NG19 7BL

# Cancellation Expenses Claim Form



## Personal details

Title  Mr  Mrs  Miss  Ms Other

Family name  First name

Date of birth 

D	D	M	M	Y	Y	Y	Y
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 N.I number

Address   
  
 Post Code

Daytime tel no.  Evening tel no.   
Email address  Occupation

## Policy details

Company name if applicable   
Policy number  Date of issue 

D	D	M	M	Y	Y	Y	Y
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Destination  Date of booking 

D	D	M	M	Y	Y	Y	Y
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Date of travel 

D	D	M	M	Y	Y	Y	Y
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 Date of return 

D	D	M	M	Y	Y	Y	Y
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Travel Agent  Tour operator

## Claim details

Reason for cancellation

# Cancellation Expenses Claim Form



Names of all persons cancelling


Date travel agent or tour operator advised of cancellation

Verbally 

D	D	M	M	Y	Y	Y	Y
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In writing 

D	D	M	M	Y	Y	Y	Y
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If cancellation was due to a person not booked to travel please state

Full name 

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Relationship 

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## Cancellation charges and payment information

Total paid to travel agent/ tour operator	£ <table border="1"><tr><td></td></tr></table>		Payment method	<table border="1"><tr><td></td></tr></table>	
Cancellation charges applied	£ <table border="1"><tr><td></td></tr></table>		Refund given	£ <table border="1"><tr><td></td></tr></table>	
Total amount claimed	£ <table border="1"><tr><td></td></tr></table>				

## Information we need from you for possible recovery opportunities

Your Travel Policy has conditions attached whereby you must provide us with any information that assist any recovery actions. This is a standard practice in the insurance market and contributions made from other insurance cover serve to keep the cost of your premium down. The information provided should not affect your renewal premium or no claims discount.

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Please answer the following questions and provide details as required. For questions that require a **Yes / No** response, please tick the appropriate boxes. Failure to do so may delay your claim

1. Do you have a bank account?

Yes

No

A bank account you hold may offer travel insurance cover as part of the benefits. Under no circumstances will your bank account information used other than to obtain a contribution from the travel insurance provider. This will not affect your bank account in any way.

Name of bank (e.g. HSBC)	Type of account	Account holder name	Account number

2. Was a credit card or debit card used to pay all or part of this trip costs?

Yes

No

Certain credit or debit cards provide an element of travel cover.

Card issuer	Type of card (e.g. Visa)	Cardholder name	Card number

3. Do you have a Household Contents insurance policy?

Yes

No

Some Household content policies provide an element of travel cover.

Name of insurer	Policyholder name	Policy number

4. Do you hold any Private Medical Insurance?

Yes

No

Name of insurer	Policyholder name	Policy number

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5. Do you consider anyone to blame for the incident?

Yes

No

If yes, please provide details

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It is a condition of the policy and your responsibility to provide sufficient documentation to support your loss. Failure to provide the required documentation, including the details of any other insurances, will delay and may invalidate your claim.

## Access to Medical Reports 1988

It may be necessary to apply for a medical report from a Doctor who has cared for you, and we ask that you give your consent by signing the claim form declaration. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988, and the procedures for dealing with the reports. You do not have to give your consent, but if you do, you can say whether you want to see the report (or have copy of it) before it is sent to us. If you say you wish to see the report, we must tell you at the same time as we write to the Doctor and we must tell him/ her you wish to see the report. You have 21 days to contact the Doctor about arrangements for you to see the report.

Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied (if you ask). If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his / her costs.

Once you have seen a report, before it is sent to us, the Doctor cannot submit it until he / she has your written consent. You can write to the Doctor asking him / her to amend any part of the report which you consider incorrect or misleading and have attached to the report a statement of your view on any part which he / she will not amend.

The Doctor is not obliged to let you see any part of a report if, in his / her opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctors intentions towards you if disclosure would likely to reveal information about you or the identity of another person who has supplied information about you, unless that person has consented to the information relates to, or has been supplied by a health professional involvement in caring for you. In such cases, the Doctor must notify you in writing and you will be limited to seeing any remaining part of the report. If it is the whole of the report that is affected, he / she must not send it to us unless you give your written consent,

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## Medical Certificate

If your holiday / Journey has been cancelled due to illness or injury this form must be completed by the usual medical practitioner of the ill/injured/deceased person (if applicable)

Please continue on a separate piece of paper if necessary. This information will be treated as PRIVATE AND CONFIDENTIAL. All other certificates are unacceptable. This form must be provided at the expense of the claimant. If a MEDICAL SELF-DECLARATION was completed, please provide details.

1. Patient name	
2. Patient age / date of birth	
3. Please confirm the exact nature of the illness/ injury or cause of death which makes cancellation of this trip necessary and / or prevents travel	
4. Date on which you were first consulted re. 3 above Where you aware of their proposed trip at this date?	
5. Has the patient received a terminal prognosis? If so please provide date prognosis was given	
6. Has the patient suffered from the same or similar condition in the past? If YES, is the present illness, in your opinion, related in any way to the past condition?	
7. a) please give dates and details of any inpatient treatment b) Date placed on a waiting list. c) Nature of the investigation surgery d) Date of hospital admission	
8. If cancellation due to pregnancy please give a) Date of confinement b) Date pregnancy confirmed c) Details of illness /injury connected with the pregnancy which gave rise to your recommendations not to travel	

(Please continue on next page.)

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<p>9. a) Give dates of any condition(s) which have been / are under supervision of a hospital/ Consultant/ Doctor or has required hospital admission or treatment in the previous 6 months</p> <p>b) Give details if the Patient is / was suffering from any chronic disease, illness or from any physical defect or infirmity, including cancerous, cardio-vascular, cerebro-vascular, renal, psychiatric or mental condition</p> <p>c) Give details of any of the conditions advised in (a) or (b) which may have a bearing on the condition(s) described in question 3.</p> <p>d) Give details if the patient is / was awaiting results of any tests, investigations or if the person is on a waiting list for any in or out patient treatment or investigation</p> <p>e) Give details of any continuous medication or changed medication or dosage increase resulting in a deterioration in the condition in the previous 6 months.</p>		
<p>10. Date on which the cancellation could have been anticipated</p>		
<p>11. Date on which you advised the holiday should be cancelled</p>		
<p>12. In your opinion, was cancellation medically necessary? If YES, was it solely due to the above condition? In your opinion when will the patient be fit for normal overseas travel?</p>		
<p>13. Please confirm that your patient was fit to travel at the time the insurance was issued.</p>		
<p>14. General remarks (Please comment on the reasons for not travelling if applicable).</p>		
<p><b>Doctors Declaration: I declare that I have examined the patient named above and / or referred to their medical records and confirm that the information given above is a true and accurate statement, and further that no material information has been withheld.</b></p>	<p><i>This section to be validated by surgery's stamp</i></p>	
<p><b>Print Name:</b></p>	<p><b>Signed:</b></p>	<p><b>Date:</b></p>

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## Settlement Details:

Claims payments made by BACS transfer or other electronic banking system can be made and credited to your account more quickly than a cheque.

By entering your bank account details, you confirm that ERV has full authority to remit monies directly to that account by the BACS or other electronic banking system. You also accept that, providing payment remitted to the bank account designated by you, ERV shall have no further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.

Name of account holder:
Type of current account, e.g. Platinum/Gold/Premier:
Name and address of Bank/Building Society:
Sort Code:
Account number:
If you require payment by cheque, to whom should the settlement be made?  <i>Please note if the bank details provided are illegible or we are unable to validate, payment will be made by cheque payable to the claimant and posted to the address provided.</i>

## Claimant(s) Declaration and signature

1. I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement
2. To the best of my knowledge and belief, I have not omitted any material information which would affect the insurers assessment of the claim
3. I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that 'Staysure Claims' will not accept any liability if any payments are not distributed proportionately to the persons concerned
4. I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to 'Staysure Claims'. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act 1988(AMRA) or other similar legislation.
5. I am aware that in insurance claim made in the knowledge that any element thereof is fraudulent is a criminal offence and that this will invalidate the policy and result in the claim being rejected. It will also render me liable to prosecution
6. I am, by this notice, aware that 'Staysure Claims' will retain a computerised record of this claim and that they may release certain information to other insurers or other interested parties. Staysure maintains all data in accordance with the provisions of the Data Protection Act, 1984.

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## Data Protection Act

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and shared with other organisations for this purpose. If you would prefer for the information given here not to be used in this way, you should tick this box

**I have read and understand that the declaration above and provided the necessary documentation to substantiate my claim**

Claimant(s) full name(s)

Claimants  
signatures

Date 

D	D	M	M	Y	Y	Y	Y
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Full name of authorised representative of the corporate policy holder (corporate and / or education group cover)

Signature of  
authorised  
representative

Date 

D	D	M	M	Y	Y	Y	Y
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I / We authorise  to act on my behalf in this matter.

Claimants  
signatures

Date 

D	D	M	M	Y	Y	Y	Y
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