Travel & Wintersports Insurance
Claim Form
for

HOLIDAY/TRIP CANCELLATION

Please complete this form, send it with all supporting documents (documents may be sent on at a later date if necessary) to **International Medical Rescue, 15 East Links, Tollgate, Eastleigh, Hampshire, SO53 3TG** or claims@im-rescue.com It will usually take about a week to 10 days for a claim to be processed. You can also contact the claims department on 0345 122 3280 24 hours a day, 7 days a week.

Please note this must be done within 31 days of your accident or sickness. Late claims may be repudiated.

The section below details the documents which you should enclose in order for us to deal with your claim. Please tick yes if enclosed and no if not.

a)	Proof of insurance, such as certificate of Tour Operators invoice.	Yes ☐	No ☐	c)	Holiday booking invoice or other documents issued as evidence of holiday/trip costs and dates.	Yes ☐	No ☐
b)	In cases of death, a photocopy of the death certificate.	Yes ☐	No ☐	d)	If the claimant was a hospital in-patient, evidence to show admission and discharge dates.	Yes ☐	No ☐

Evidence of cancellation charges.

e) **Either:**

For all inclusive tours (package holidays) organised by a Tour Operator please attach the Tour Operator's cancellation invoice showing cancellation charges levied and any refund made together with the tour operator's booking conditions. Yes ☐ No ☐

or

For independently booked holidays or trips please attach the unused travel tickets (or vouchers) together with official confirmation of the cancellation charges levied and any refunds made from the Travel provider e.g. airline or coach. Yes ☐ No ☐

NOTE

If the cancellation is due to medical reasons please ensure the medical certificate on this claim form is fully completed by the patients doctor. In the event of cancellation because of bereavement a copy of the death certificate will also be required.

SIGNATURE

Please sign and date the form on the final page.

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 the course of our normal working hours to discuss your claim and/or request further details. Please advise us of numbers on which you can be reached:

……or……..

Failure to produce these documents above will delay the processing of your claim

V2

PLEASE COMPLETE IN BLOCK CAPITALS

1. Claimant's title..... .....

   Forenames: .....

   Surname: .....

2. Home Address:

   .....

   .....

   .....

   Post Code: .....

   e-mail: .....

3. Contact Telephone No.

   Home: .....

   Mobile: .....

4. Occupation: Date of Birth:

5. The destination and country of this holiday/trip:

6. a. Date insurance issued:

   b. Policy ref no. or certificate no.

7. The period of your holiday/trip giving total number of days

   From: To:

   Total no. of days:

8. No. of people covered by the policy:

9. Name of tour operator from whose brochure you booked

   (if relevant):

10. Date holiday/trip booked:

11. a) Please advise the date on which you either decided or were advised to cancel:

    b) Please advise the date on which you gave cancellation instructions either:

    i) Verbally (including telephone) ☐ ii) Written (including fax) ☐

    c) If the dates provided in 11(a) and 11(b) differ, please explain the reason:

12. Please describe the exact circumstances which have caused you to cancel the holiday. If the reason for cancellation is not of a medical nature please supply suitable documentary evidence to support the claim.

13. 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.	.....	.....	.....

14. Was the person named on the medical certificate due to travel with you? YES ☐ NO ☐

15. Should we require further medical information, it would help us to be able to contact the GP/attending specialist ourselves.

    Does the patient agree to this? Yes ☐ No ☐

    Patient's name (printed)

    Signed (by patient) .....

    Dated .....

MEDICAL CERTIFICATE

This Medical Certificate is to 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

PLEASE COMPLETE IN BLOCK CAPITALS

16. Name of person for whom these details apply:

17. How long have you been the Patient's GP?

18. Age and date of birth:

19. Relationship to claimant (if known):

20. 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 .....

21. (a) Please state exact nature of the illness/injury which made cancellation of the holiday/trip medically necessary and prevents travel:

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(b) Has the patient received a terminal prognosis? Yes ☐ No ☐

(c) Details of any previous medical history relevant to the above condition:

.....

.....

(d) Was the patient under any treatment or receiving medication (relevant to the above condition) Yes ☐ No ☐

If yes, please provide details: .....

.....

(e) Was the patient on a hospital waiting list for treatment for the condition which caused cancellation? Yes ☐ No ☐

If yes, please provide details and dates: .....

.....

22. 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.: .....

23. Were you aware of the holiday plans when you were first consulted? Yes ☐ No ☐

24. Please confirm the date that cancellation could have been reasonably anticipated: .....

25. Was the patient due to travel on the cancelled trip? Yes ☐ No ☐

If yes a) Was the patient fit to travel on the date the policy was issued? Please refer to question 6a) before answering this. Yes ☐ No ☐

b) Was the patient travelling or had booked to travel contrary to medical advice? Yes ☐ No ☐

If no c) What was the patient's state of health on the date the insurance policy was issued? Please refer to question 6a) before answering this.

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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)

PLEASE COMPLETE IN BLOCK CAPITALS

26. Certain household contents policies provide an element of travel cover. Do you have a household contents insurance policy or if you are living with your parents do they have a policy? Yes ☐ No ☐

If yes, please supply the name and address of the insurance company and policy number.

Name:

Branch Address:

Policy No:

27. Do you have any other insurance which may cover this incident? Yes ☐ No ☐

If yes, please supply details of the policy(ies):

28. Was a credit card used to pay all or part of the holiday/trip cost? Yes ☐ No ☐

If yes, please supply the following information:

Name of card: Cardholders name:

Name of card issuer: (if different) Credit card no: | | | | | | | | | | | | | | | | |

29 Please provide your bank account details:

Name of Account holder: .....

Name of Bank: .....

Account Number: .....

Sort Code: .....

Type of Account e.g. Gold: .....

Please detail below the amount of the claim (excluding insurance premiums)

INDEPENDENT HOLIDAY/TRIP

Travel Ticket Cost	£	Date Paid:
Amount Refunded	£	
NETT CLAIM	£	
Accommodation cost/or other	£	Date paid:
Amount Refunded	£	
NETT CLAIM	£	
Other Costs	£	
Total amount Claimed	£	

PACKAGE HOLIDAY/TRIP

Deposit Paid	£	Date Paid:
Balance Paid	£	Date Paid:
Total	£	
Deduct Refund Received	£	
Other Costs	£	
Total amount Claimed	£	

Other Costs please itemise below:

FOR OFFICE USE ONLY

FOR OFFICE USE ONLY

TOTAL £ TOTA X/S £ TOTAL NETT £

And Finally…..

To finalise your claim please sign the declaration below, however before doing so please read the following carefully:-

- Please study the policy wording and read the terms and conditions that relate to your claim.
- You are responsible for the cost of obtaining any documentation in support of your claim.
- This Insurance contains rights of subrogation and I confirm I assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever necessary to secure such rights.
- Information on this form will be used by insurers to deal with any claim. Insurers may also pass this and any other information to other insurers and organisations involved in dealing with any claim. Insurers also share information to prevent fraud.

DECLARATION

I declare that, to the best of my knowledge and belief, all information stated herein is correct and that the insurance company is subrogated with all rights I may have against any third party(s).

I have not withheld any information from insurers within my knowledge connected with my claim.

I agree to provide further information or documentation that may be reasonably required.

SIGNATURE OF CLAIMANT: …… DATE:.....

SIGNATURE OF PARENT/GUARDIAN:…… DATE:……

RELATIONSHIP:……..

CONTACT NUMBER:…….....

CONTACT EMAIL:……..

Warning

Making a fraudulent or knowingly exaggerated claim is a criminal offence and could render the offender liable to prosecution.

Copy

Please take a copy of this claim form and any attachments for your records and send the original with all supporting documents to **International Medical Rescue, 15 East Links, Tollgate, Eastleigh, Hampshire, SO53 3TG**