GLOBAL TRAVEL INSURANCE
TRAVEL CLAIMS FORM

FOR OFFICE USE ONLY

PERSONAL DETAILS

Name of Insured Person ....(Mr, Mrs, Miss, Ms, other)

Date of Birth / / Occupation ....Nationality ....

Passport Details: Number ....Country of Issue ....

Correspondence Address ....

....Post Code ....

Telephone Number: Home ....Work/Daytime ....

TRAVEL DETAILS

Country ....Resort .... Hotel ....

Dates of Travel: From ....To ....

Type of Holiday (e.g. Air/Coach) ....Date booked ....

How was the holiday paid for? e.g. Credit Card/Cash/Cheque/Other ....

INSURANCE DETAILS

Name of Travel Company (or other) who issued your Insurance ....

Please state the Insurance Certificate Number (including Prefix) ....

Date Insurance purchased ....Premium Paid £ ....

Have you made ANY other insurance claim in the last 5 years? YES/NO. If YES Please append details.

DATA PROTECTION NOTICE

We may use your information together with other information for insurance, administration, underwriting, statistical analysis, claims, research and customer services. We will disclose your information to our service providers, agents and business partners for these purposes. We may send your information in confidence for processing to other companies acting on our instructions including those located outside the European Economic Area.

In the event of an insurance claim we share the claims information with other Insurers via the Claims and Underwriting Exchange register administered by Insurance Database Services Limited to check details and prevent fraudulent claims. We may also disclose your information to agents and other insurers to investigate or prevent fraud. If you would prefer that the information given here is not used in that way you should tick this box ☐

We may pass information to our service providers to assist with the management of your claim. Medical Services may include any of the following independent services, a medical notes review, a specialist medical examination or other medical related services. By signing and returning this claims form, you consent to our processing your sensitive personal data such as health data for the above purposes.

Please complete the appropriate section on the following pages and then sign the declaration below:-

I declare the information given in this form to be true and accurate and in respect of claims involving illness or injury I authorise Towergate Chase Parkinson to contact the doctor named within this form, my doctor in the U.K. and any medical assistance organisation utilised in connection with this claim, for any information as may be required and authorise the release of such information to Towergate Chase Parkinson. Furthermore, and in respect of any claim, I agree, upon settlement, to transfer all rights of recovery and salvage to the Insurers.

I confirm that I am authorised to act on behalf of all named insured and that any cheque in settlement will be payable to me on their behalf.

Signed .... Date ....

IMPORTANT: ***The following documentation must be enclosed in order that your claim may be processed. Originals are required, settlement cannot be made on photocopied documents.***

CANCELLATION

Your Insurance Policy and receipt of Premium Paid

Your Travel Booking Invoice (showing your itinerary and dates of travel)

Your Cancellation Invoice

Copy of Death Certificate (if applicable)

Completed Medical Certificate if Cancellation for Medical Reasons (see overleaf)

Redundancy Letter (if applicable)

MEDICAL EXPENSES

Your Insurance Policy and receipt of Premium Paid

Your Travel Booking Invoice (showing your itinerary and dates of travel)

Receipts or Invoices for the Amount Claimed

Any Unused Airline Tickets, Accommodation Vouchers etc.

LUGGAGE AND PERSONAL MONEY

Your Insurance Policy and receipt of Premium Paid

Your Travel Booking Invoice (showing your itinerary and dates of travel)

Receipts or Other Evidence of Value for the Items Claimed

A Written Report from the Person/Company To Whom the Loss/Damage was Reported

Photocopy of Your House Contents Insurance Schedule

TRAVEL DELAY

Your Insurance Policy and receipt of Premium Paid

Your Travel Booking Invoice (showing your itinerary and dates of travel)

A Letter from the Airline (or similar) Confirming the Scheduled and Actual Time of Departure.

PLEASE SEND THIS COMPLETED CLAIMS FORM WITH THE ABOVE DOCUMENTS TO:-

TOWERGATE CHASE PARKINSON – TRAVEL INSURANCE SPECIALISTS

P.O. Box 416, West Byfleet, Surrey KT14 7YE

Towergate Chase Parkinson is part of the Towergate Underwriting Group Limited

Authorised and regulated by the Financial Services Authority

CANCELLATION

Names of all those cancelling and thus making a claim:-

1 . . . . .Age . . . . 2 . . . . .Age . . . .

3 . . . . .Age . . . . 4 . . . . .Age . . . .

5 . . . . .Age . . . . 6 . . . . .Age . . . .

Date of Cancellation . . . . Reason for Cancellation . . . .

Total Holiday Cost £

Total Amount Paid to Date £

Amount of Refund from Travel Company £

Amount claimed being the cancellation charges levied after such refund £

Notes

If your cancellation is for medical reasons the Doctors Certificate below will need to be completed and officially stamped by the sick persons General Practitioner or Hospital Consultant. In the event of Death a copy of the Death Certificate will usually suffice but must be accompanied by the name and address of the Deceased's doctor. in the event of redundancy an original letter must be produced from the employer confirming that the Redundancy falls within the terms of the current Redundancy Act, along with exact date of notification. An original letter/notification from the court is required regarding Jury service attendance confirming the dates of notification.

DOCTORS CERTIFICATE

To be completed at the Insured's expense, in its entirety by a qualified medical practitioner (GP or hospital consultant) in respect of a cancellation claim arising from illness or injury.

Full name of sick person whose condition prevents the journey taking place . . . . Relationship to the Insured (if applicable) . . . .

Date of Birth . . . . Specific Diagnosis . . . .

Date of onset of first symptoms of illness/injury . . . .

Date you first saw the patient in relation to this condition . . . .

Did you provide confirmation (either verbal or written) to the insured person prior to the trip that there is no reason why they should not travel? . . . .

Is this an acute exacerbation of a chronic condition? . . . .

In your medical opinion what was the exact date that cancellation of the travel arrangements was required? . . . .

Please give the reason why the travel arrangements were medically inadvisable . . . .

. . . .

Has the patient suffered from the above condition before? YES/NO . . . .

If YES please give details . . . .

At the time the insurance was purchased (see overleaf) was the person mentioned above

(a) awaiting or receiving tests, investigations, treatment, referral or the result of such? YES/NO

(b) receiving any medication, please list. . . . .

. . . .

In the event of pregnancy state: 1. The E.D.D. 2. The L.M.P. . . . .

Has there been a complication of the current pregnancy? YES/NO

If YES please give details . . . .

Signed . . . . Date . . . . Doctors Stamp to Validate . . . .

Name . . . . .Position . . . .

Do you hold any other insurance that may provide cover for any part of this claim? If so, please provide the name of the policy provider, their correspondence address and your policy/membership/account number.

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TRAVEL DELAY

Please list the names of all those delayed and thus making a claim:-

1 . . . . .Age . . . . 2 . . . . .Age . . . .

3 . . . . .Age . . . . 4 . . . . .Age . . . .

5 . . . . .Age . . . . 6 . . . . .Age . . . .

Please give details of your original intended departure:-

Date...........................Time ....Departing from (name of Airport or similar)..

Please give details of your actual departure after the delay:-

Date...........................Time ....Departing from (name of Airport or similar)..

What was the reason for the delay?...

....

....

MEDICAL EXPENSES, REPATRIATION AND CURTAILMENT

Name of sick, deceased or injured person . . . . Date of Birth . . . .

Nature of injury, illness or cause of Death . . . . Date of injury/illness/death . . . .

If injury, how did it occur? . . . .

If illness, has the condition been experienced previously? YES/NO . . . .

If YES please give date of first occurrence . . . .

Name and address of the Doctor who treated you abroad . . . .

. . . .

Date of Treatment: From: . . . . .To: . . . .

If hospitalised please state: Date of admission . . . . Date of Discharge . . . .

Name and address of hospital . . . .

Did you return to the U.K. on your intended date? YES/NO

If no please give details, including your return date and the names of any persons who accompanied you

. . . .

Did you call the 24 hour Medical Assistance Service? YES/NO

Name and address of your usual G.P. in the U.K.

Are you a member of a Private Health Insurance Plan? YES/NO

If YES please state the name and address of the Company and the Policy No. . . . .

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Do you hold any other insurance that may provide cover for any part of this claim? If so, please provide the name of the policy provider, their correspondence address and your policy/membership/account number.

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PLEASE LIST THE ITEMS FOR WHICH YOU WISH TO CLAIM AND ATTACH THE ORIGINAL RECEIPTS/INVOICES

DATE OF SERVICE	NAME OF DOCTOR OR DETAILS OF THE SERVICE PROVIDED	AMOUNT	HAVE YOU PAID OR IS THE AMOUNT STILL OWING TO THE SUPPLIER

LUGGAGE AND PERSONAL MONEY

Is the claim in respect of:- ❑ PERMANENT LOSS ❑ TEMPORARY LOSS ❑ DAMAGE *(Tick as Appropriate)*

When was your property last seen or known to be undamaged: Date: . . . . Time: . . . . Place: . . . .

When did you discover the loss or damage: Date: . . . . Time: . . . . Place: . . . .

Where were you between the times . . . .

Was the property in your custody at the time of loss/damage? YES/NO (Delete as Appropriate)

If NO please give details:

Have you reported the loss/damage YES/NO (Delete as Appropriate)

To whom: . . . . Date: . . . . Time: . . . .

Have you been in subsequent contact with them concerning recovery? YES/NO (Delete as Appropriate)

If YES please give details . . . .

NOTE:

A WRITTEN REPORT MUST BE SUPPLIED FROM THE PERSON OR COMPANY TO WHOM THE LOSS/DAMAGE WAS REPORTED TO CONFIRM THE LOSS/DAMAGE AND THE NON-RECOVERY.

Please provide full details concerning the circumstances of loss/damage . . . .

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Name and address of your House Contents and All Risk Insurers: . . . .

. . . . Policy No . . . .

Do you hold any other insurance that may provide cover for any part of this claim? If so, please provide the name of the policy provider, their correspondence address and your policy/membership/account number.

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PLEASE LIST THE ITEMS FOR WHICH YOU WISH TO CLAIM AND ATTACH RECEIPTS OR OTHER EVIDENCE OF VALUE WHERE AVAILABLE

NAME OF OWNER OF THE PROPER	DESCRIPTION OF ITEM	TICK AS APPROPRIATE		SHOP AND TOWN WHERE PURCHASED	DATE OF PURCHASE	PURCHASE PRICE	AMOUNT CLAIMED	TICK AS APPROPRIATE			**FOR OFFICE USE ONLY**
		Lost	Damaged					Enclosed	To Follow	Not Available	
						TOTAL					