

## Trip Cancellation Claim Form

**Please return this claim form together with all supporting documentation to:**

**Fly-sure Claims Dept Birchin Court, 3rd Floor, 20 Birchin Lane, London EC3V 9DU Telephone 020 7739 3444**

Fly-Sure is arranged by Marcus Hearn, a trading name of Giles Insurance Brokers Ltd, Registered in Scotland, Registered Number 108909. Giles Insurance Brokers Ltd is authorised and regulated by the Financial Services Authority under reference 311786. This insurance is administered by FirstAssist Insurance Services Limited, Marshall's Court, Marshalls Road, Sutton, Surrey SM1 4DU. Registered in England and Wales. No 04617110 and is Authorised and Regulated by the Financial Services Authority, FSA Register No. is 310671. This insurance is underwritten by Great Lakes Reinsurance Office at Plantation Place, 30 Fenchurch Street, London, EC3M 3AJ. Registered in England and Wales No. 2189462 and is authorised and regulated by the Financial Services Authority. FSA Register No. is 202715

<b>Name</b>		<b>Certificate number</b>	
-------------	--	---------------------------	--

Further to your request for a Claim Form, please ensure that you complete it fully and return it to us.

**PLEASE ENSURE YOU SIGN AND DATE THE FORM ON PAGE 4. ON QUESTIONS WHICH REQUIRE A YES/NO RESPONSE, PLEASE CIRCLE THE APPROPRIATE ANSWER. FAILURE TO DO SO COULD DELAY YOUR CLAIM.**

Please check that we have correctly stated your name, initial(s), address and postcode and amend if necessary.

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 your numbered policy schedule (and endorsements if your policy was endorsed) – photocopies are acceptable for annual policies.
- b) Evidence of your trip costs such as the booking invoice or original travel tickets, showing the trip dates or travel tickets, ferry coupons etc.

<b>Attached (Please Tick)</b>	
<b>Yes</b>	<b>No</b>

**Evidence of cancellation charges. Either:-**

- c) 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.

--	--

or

For independently booked holidays you must submit the unused travel tickets (or vouchers) together with official confirmation of the cancellation charges levied and any refunds made by Airline/Ferry Company/Coach Company.

--	--

**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 photocopy of the Death Certificate will be required.

**EMAIL AND TELECLAIMS**

If you have no objection, in an effort to promote speedier and more customer-friendly claims handling we may find it easier to e-mail you or telephone you during the course of our normal working hours to discuss your claim and/or request further details. Please confirm your e-mail address and/or advise us of any relevant numbers on which you can be reached in the spaces below.

--	--

**CLEAR BLOCKED CAPITALS MUST BE USED PLEASE**

<b>Claimant's title MR/MRS/MISS/MS</b>		<b>Please confirm your Certificate Number.</b>		
<b>Forenames</b>				
<b>Surname</b>				
<b>Address</b>		<b>Date of policy issue (this is important):</b>		
<b>Postcode</b>		<b>DAY:</b>	<b>MONTH:</b>	<b>YEAR:</b>
<b>Telephone No. Daytime</b>		<b>The period of your trip</b>		
<b>Evening</b>		<b>From:</b>	<b>To:</b>	
<b>Mobile</b>		<b>Total no. of days</b>		
<b>Email</b>		<b>Number of people covered by this policy:</b>		
<b>Occupation</b>		<b>The tour operator from whose brochure you booked (if relevant):</b>		
<b>Date of Birth</b>				
<b>The destination and country of this holiday/trip:</b>		<b>Day</b>	<b>Month</b>	<b>Year</b>
<b>The day on which your trip was 1<sup>st</sup> booked</b>				
<b>Please advise the date on which you were advised to cancel</b>				
<b>Please advise the date on which you gave cancellation instructions, and how</b>				
<b>How were Instructions given</b>	<b>Verbally</b>	<b>YES</b>		<b>NO</b>
	<b>Written</b>	<b>YES</b>		<b>NO</b>

**Method of transport: (please provide original travel tickets).**

**Failure to answer these questions may delay your claim**

**Certain household contents/all risks policies provide travel cover.**

**Do you have a household contents/all risks 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:**

<b>Name</b>		<b>Policy Number</b>	
<b>Address</b>			

**Do you have a bank account?**

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

**YES / NO**

<b>Bank Account Name</b>		<b>Account Type (e.g. Premier)</b>	
<b>Account Number</b>		<b>Sort Code.</b>	

**Was a credit card used to pay all or part of the trip cost (certain credit cards may provide an element of travel cover)?**

**YES / NO**

**If yes, please supply the following details**

<b>Type of card:</b> (e.g Switch, Maestro, Mastercard, VISA etc)		<b>Name of Card issuer:</b> (e.g HSBC, Barclaycard etc)	
<b>Cardholders Name</b>		<b>Card Number</b>	

**CANCELLATION COSTS**

**IMPORTANT**

Please attach **ORIGINAL** documents and invoices as photocopies are **NOT** acceptable.  
Please continue on a separate sheet, if necessary.

Type of expenses (e.g. Flight, Hotel etc))	Name of provider (Airline, Hotelier etc )	Amount	Type of expenses (Airline, Hotelier etc )	
			PAID	UNPAID
<b>TOTAL</b>				

**CURTAILMENT ONLY**

**IMPORTANT**

The circumstance leading to the curtailment of your holiday must be supported by independent documentary evidence from the attending medical practitioner or other relevant party.

Names of all persons curtailing	Total holiday cost per person excluding insurance premium
	£
	£
	£
	£
<b>Date you returned:</b>	
<b>Date you should have returned:</b>	

**IMPORTANT NOTICE**

**In the event of this claim being successful and payment authorised in your favour, the amount being claimed can be paid directly into your bank account using Bank Automated Clearing Services (BACS). In order to do this the Company will require your bank details. Please complete the information below:**

<b>Name of Bank:</b>	
<b>Full Branch Address:</b>	
<b>Bank Account Number:</b>	
<b>Sort Code</b>	
<b>Account Name:</b>	

**PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION**

Prior to returning the claim form, please study the policy wording and read the terms and conditions as they relate to your claim.

**WARNING**

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

The information on this form will be used by the Insurer and their agents to deal with any claim. The Insurer and their agents may also pass this and any other information to other insurers and organisations involved in dealing with any claim. The insurer and their agents may also share information to prevent fraud.

**PROTECTION OF YOUR PERSONAL DATA**

The security of your personal information is very important to us and we are compliant with all current data protection legislation. All personal information that you supply to us either in respect of yourself or other individuals in connection with this claim will be treated in confidence by the insurer and their agents and will be held by us for the purpose of providing and administering your claim. This may involve the collection and processing of sensitive data (as defined in the Data Protection Act 1998) and if you complete an application form for our products and/or services you will be giving your consent to such information being processed by the Insurer and their agents.

It may be necessary to pass your personal and sensitive data to other companies for processing on behalf of the insurer and their agents. Some of these companies may be based outside Europe in countries which may not have the laws to protect your personal data, but in all cases the insurer and their agents will ensure that it is kept securely and only used for the purposes for which it was provided.

**INACCURATE DATA**

If you believe that we are holding inaccurate information about you, please contact the team responsible for administering your claim and they will be happy to correct any errors.

**DECLARATION. PLEASE CIRCLE "YES" TO CONFIRM YOU HAVE READ AND UNDERSTOOD EACH LINE:**

I/We declare that the information contained within this claim form is true and correct to the best of my/our knowledge and belief.	<b>YES</b>
I/We have not withheld any information or documentation from insurers within my/our knowledge connected with the claim.	<b>YES</b>
I/We assign to insurers all rights of recovery / salvage against any person or organisation and will do whatever else is necessary to secure such rights.	<b>YES</b>

<b>SIGNATURE OF CLAIMANT:</b>		<b>DATE:</b>	
-------------------------------	--	--------------	--

### 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 (**in block capitals**) answering each question as fully as possible.

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

Name of person to whom these details apply			
How long have you been the Patient's GP			
Age and date of birth			
Relationship to claimant (if known)			
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	
Please state exact nature of the illness/injury which made cancellation of the trip medically necessary and prevents travel			
Has the patient received a terminal prognosis?	Yes	No	
Details of any previous medical history relevant to the above condition			
Was the patient under any treatment or receiving medication (relevant to the above condition) Yes / No If yes, please provide details			
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			
If the cancellation has occurred due to a pregnancy related condition please describe the condition and why the pregnancy necessitates cancellation			
Date pregnancy confirmed		E.D.D.	
Were you aware of the trip plans when you were first consulted	Yes	No	
Please confirm the date that cancellation could have been reasonably anticipated			
Was the patient due to travel on the cancelled trip?	Yes	No	
Please refer to page two of the claim form before answering this			
If yes:	Yes	No	
(a) Was the patient fit to travel on the date the trip was booked?	Yes	No	
(b) Was the patient travelling contrary to medical advice?	Yes	No	
If no:			
(c) What was the patient's state of health on the date the trip was booked?			

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

<i>Name</i>		<i>Name and Practice Address (official stamp)</i>
<i>Signature</i>		
<i>Qualifications</i>		
<i>Date</i>		