CA CANCELLATION BEFORE DEPARTURE OF A TRIP

Postcard Claims
1 Tower View
Kings Hill, West Malling
Kent
ME19 4UY
Email:
claims@postcardtravelinsurance.co.uk
Web:
www.postcardtravelinsurance.co.uk

Dear Customer,

In order that we can process your claim quickly, please complete all relevant sections of the claim form, giving as much detail as you can and **return it to us at the above address,** together with the following **ORIGINAL** documentation. Please note that in the interest of protecting ourselves from fraud we are unable to accept photocopied receipts or invoices.

We recommend that you keep your own copy of all documents forwarded to us.

To help you enclose the correct paperwork to support your claim we have put together a checklist. Please ensure you read this carefully as failure to supply the correct documents may result in your documents being returned to you.

CHECKLIST OF DOCUMENTS REQUIRED

ALL CLAIMS

- ☐ DOCUMENTATION SHOWING YOUR TRAVEL DATES AND FULL COST OF THE TRIP (booking invoice)
- ☐ PROOF OF INSURANCE i.e. certificate/schedule or confirmation email. As claims handlers we do not hold this information
- ☐ DOCUMENTATION FROM YOUR TOUR OPERATOR / TRAVEL AGENT SHOWING THE CANCELLATION COSTS AND ANY REFUND GRANTED (cancellation invoice)
- ☐ THE MEDICAL CERTIFICATE COMPLETED BY YOUR GENERAL PRACTITIONER * see below
- ☐ OTHER SUPPORTING DOCUMENTATION IFCANCELLATION NOT DUE TO MEDICAL REASONS
- ☐ EVIDENCE OF PRE-PAYMENT FOR EXCURSIONS BOOKED THE SAME TIME AS THE MAIN TRIP

IF YOU HAVE DISCLOSED ANY PRE-EXISTING MEDICAL CONDITIONS TO THE INSURANCE COMPANY

- ☐ ENDORSEMENT CONFIRMING THAT YOU HAVE PURCHASED THIS ADDITIONAL COVER
- ☐ PROOF THAT YOU HAVE PAID ANY ADDITIONAL PREMIUM REQUIRED

IF YOU ARE CANCELLING DUE TO THE UNEXPECTED DEATH OR ILLNESS OF A CLOSE RELATIVE OR TRAVELLING COMPANION

- ☐ COPY OF DEATH CERTIFICATE
- ☐ OUR MEDICAL CERTIFICATE COMPLETED BY THE GENERAL PRACTITIONER OF THE PERSON WHOSE ILLNESS OR DEATH CAUSED YOU TO CANCEL *

ANY OTHER REASONS FOR TRIP CANCELLATION

- ☐ NEED TO BE SUPPORTED IN WRITING BY YOUR EMPLOYER OR RELEVANT AUTHORITY.

You should note that all the information provided to us on this form will be stored electronically in accordance with The Data Protection Act and shared with the Insurance Industry Fraud Prevention Unit. If you make a fraudulent or intentionally exaggerated claim this will invalidate your claim and we will pursue a recovery through the civil courts in all cases.

We do understand that it may take time to collect all the documentation required but please try to submit your claim as soon as possible after the event.

Yours faithfully,

Travel Claims Facilities

CLAIM FOR CANCELLATION OF A TRIP – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

REASON FOR CANCELLATION - Please tick one box only

ILLNESS: **INJURY:** **DEATH:** **OTHER:**

TO BE COMPLETED BY THE CLAIMANT

Title:

First Name: **Surname:**

Address:

Post Code:

Telephone: **Date of Birth:** DD / MM / YY

Email:

DETAILS OF THE INSURANCE POLICY

Where / who did buy your insurance from:

Policy name: **Date Policy Issued:** DD / MM / YY

Policy number:
Found on Schedule, Certificate, or Booking Invoice

Master Policy Number:
Found on policy wording (ABCDE400…)

Destination:
i.e. Europe / Worldwide

Medical Screening reference number:

DETAILS OF TRIP

Travel Agent / Tour Operator:

Date Trip Booked: DD / MM / YY **Date final balance paid:** DD / MM / YY

Method of payment (cash, cheque, debit card, credit card)**:**

Trip Dates From: DD / MM / YY **To:** DD / MM / YY

DETAILS OF CLAIM

Date you were advised to cancel: DD / MM / YY **Date you cancelled in writing:** DD / MM / YY

If the period between the above dates is more than 3 days, please advise why:

How many days were there between cancelling and travelling:

CLAIM FOR CANCELLATION OF A TRIP – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

Please describe the circumstances leading up to the decision to cancel:

PLEASE LIST ALL PEOPLE MAKING A CLAIM UNDER THIS POLICY:

Name:		**Date of birth:**	/ /
Name:		**Date of birth:**	/ /
Name:		**Date of birth:**	/ /
Name:		**Date of birth:**	/ /
Name:		**Date of birth:**	/ /
Name:		**Date of birth:**	/ /

CALCULATION OF TOTAL BEING CLAIMED BY YOU

Total amount paid for travel i.e. flight, coach: £ **Accommodation:** £

Total amount paid for pre-booked excursions: £

Total of the above amounts = Amount paid for holiday:	£
Less the insurance premium if included in booking (this is non-refundable)**:**	£
Less any refund/s received:	£
Total being claimed (before policy excess deducted if applicable)**:**	£

Are any of these expenses recoverable under any <u>other</u> insurance policies you hold e.g. annual credit card cover or alternate travel insurance policies? Yes: No: . If yes, please give details:

Name of Insurer: **Policy Number:**

Address:
Postcode:

CLAIM DECLARATION:

- ✓ I/We declare that all the details provided above are true and accurate to best of my knowledge.
- ✓ I/We give consent for Travel Claims Facilities to seek recovery of monies paid where other insurers cover the same risk, or from third parties who may be held liable.
- ✓ I/We understand that details of this claim may be passed to the insurance industries central claim register
- ✓ I/We understand that if a claim is found to be fraudulent of exaggerated that this will invalidate the whole claim and Travel Claims Facilities may seek to recover any costs through the civil courts
- ✓ I/We confirm that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf, and I can confirm that I understand that neither Travel Claims Facilities or the underwriters of the policy will accept responsibility if any payments are not distributed proportionately to the persons concerned.

Once you have read and agreed to the above declarations, please sign and date below.

Signed: **Dated:** DD / MM / YY

Please print name:

MEDICAL CERTIFICATE

This medical certificate is to be completed by the General Practitioner of the person whose death, illness or injury caused this claim. NOTE: Any charges for completion of this form are the responsibility of the claimant.

Doctors Name:

Doctors Qualification:

Telephone Number:

Doctors Signature:

Todays Date: DD / MM / YY

Surgery Stamp

PLEASE ANSWER ALL QUESTIONS IN FULL (N/A or dashes are not acceptable).

Patients name: **Date of Birth:** DD / MM / YY

Patients address:

Post code:

1. **Please detail the medical condition that necessitated this patient to cancel his / her planned trip:**

2. **Is this the first diagnosis of this condition? Yes: No:**

3a. **What was the date of diagnosis for this condition?** DD / MM / YY

3b. **Please advise the date of any previous diagnosis** DD / MM / YY

4. **If this episode is an exacerbation of a recurring or chronic condition, please advise the date of deterioration?**

5. **Was the patient referred to a consultant? Yes: No: Date patient seen by consultant:** DD / MM / YY

6. **Please advise if this condition has caused the patient to be hospitalised and the dates involved:**

7. **Date/s of any relevant diagnostic tests and results:**

8. **Was the treatment emergency, elective or expected?**

9. **Has the patient ever suffered from the following medical conditions? If yes, please provide details and dates:**

Any cardiac or circulatory conditions?	
Any respiratory conditions?	
Any type of diabetes?	
Hypertension?	
Stroke?	
Any type of Cancer?	

10. **If the patient has been under this care of a consultant or hospital in the previous two years please give brief details?**

11. **Please list all regularly prescribed medication including inhalers along with date first prescribed:**

Before this illness, injury or death **After this illness or injury**

In order for us to obtain the required report would you please be kind enough to complete and sign the details below and return this form to us, which will allow us to contact your / the patient's General Practitioner for more detailed information which will assist in the assessment of your claim.

ACCESS TO MEDICAL REPORTS ACT 1988

This policy is insured by Union Reiseversicherung UK (URV), if they or any of their agents require information from your doctor in respect of your insurance you have certain rights under the Access to Medical Reports Act 1988: -

- Your consent* is required before URV or anyone acting as their agent can apply for a report and you may see the report before it is supplied to URV or their agents, or at any time during the six months after that.
- If you disagree with the contents of the report or consider it to be misleading you may ask your doctor to amend it. If the doctor disagrees you may add your own written comments. The doctor may withhold all or part of the report from you if he/she thinks that this would be in your best interests, or that of others. . Alternatively you can refuse consent*.
- At no time will the report be sent to URV or anyone acting as their agent without your consent.

*You can refuse to give your consent however this may mean we are unable to deal with your claim

Charges made by the doctor for providing such a report to URV are for your own account, as they are not covered by this policy.

DETAILS OF THE PATIENTS / YOUR USUAL GENERAL PRACTITIONER

Patient Name:

Name of General Practitioner:

Surgery Address:

Post Code:

Telephone Number:

Name of Hospital admitted to (if applicable):

Consultant Name:

DECLARATION

I consent to URV or anyone acting as their agent, seeking medical information from any doctor who has any at any time attended me concerning anything which affects my/the patient's physical and/or medical health. I authorise the giving of such information during and after my lifetime.

I have been informed of and understand my rights under **Access to Medical Reports Act 1988** (see above).

I do / do not wish to see any report before it is sent: I do: **I do not:**

Patients name: **Date of Birth:** DD / MM / YY

Patients address:

Post code:

Signature of patient or **Signature of next of kin**

Date: DD / MM / YY

Please print name:

If next of kin, please advise your relationship to the patient:

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SETTLEMENT BY BACS

For your convenience and to offer an efficient smoother service, we would like to pay any claim settlement due directly into your bank account. Please provide your details on this form, remembering to sign and date below.

If you do not wish to provide your bank details, any settlement due on your claim will be issued by cheque and may take a little longer to process.

YOUR DETAILS

Name of Claimant

BANK ACCOUNT DETAILS

Name of Payee

This should be the same as held on the bank account

Bank Name

Bank Address

Bank Address

Bank Address

Country **Post Code**

Bank Account number

Sort Code - -

Signed **Dated**

If your bank account is held abroad, please also enter the following details:

IBAN / BIC number

Swift code

We do not accept liability for any errors due to the incorrect bank details being provided by you.

Office Use Only	URV	£	Auth:	Dated: