

# travel insurance claim form

## CANCELLING AND CUTTING YOUR TRIP SHORT

- Please ensure you provide all requested information and documentation
- Please keep a copy of your claim
- Usually we'll respond to your claim within 10 working days from the day we receive it

**return address:** Right Cover – claims team  
PO Box 9386, Chelmsford, Essex, CM1 9BD

OFFICE USE ONLY:      **NEW**      **EXISTING**

Claim number:

Date received:

## your details

Title      First name  
     

Surname

Date of birth      Passport number  
     

Occupation

Email address

Home address

County      Postcode  
     

Home phone      Mobile  
     

Work phone      Fax  
     

Name of your travelling companion      Their contact number  
     

## your policy

Policy number      Date issued  
     

Travel agency name and location      Travel consultant's name  
     

Date insurance paid for      Date travel arrangements booked  
     

Date departed      Date returned  
     

## your health

Did you apply and pay for any Existing Medical Condition cover?  
Yes       No

If **Yes**, please provide the reference number below

## other insurance/claims

Can you claim/have you claimed from any other source? (e.g. airline, transport provider, travel agent, third party etc.)      Yes       No

Details      Amount received  
      £

Do you have private health insurance?      Yes       No

Name of fund      Policy number  
     

Can you claim from them for this event?      Yes       No

If **Yes**, include your statement of benefits giving evidence of the amount received.

Have you made a travel insurance claim in the past?      Yes       No

If **Yes**, please give details

Date      Company name  
     

Amount claimed      Type of claim  
£      

Certain credit cards may provide basic travel insurance cover which may also cover your loss. Do you have credit card/s?      Yes       No

If **Yes**, with which provider and which card type/s?

Provider (e.g. Barclays)      Type (e.g. Gold Visa)  
     

Did you purchase part or all of your travel on the card/s?      Yes       No

## settlement of your claim

We will deposit the amount payable directly to the bank account you nominate.  
*NOTE: We cannot deposit to credit card or non-UK accounts.*

Sort code (must be 6 digits)      Account number (must be 8 digits)  
     

Name of account holder      Name of bank  
     

## warning

To avoid passing the cost of dishonest and fraudulent claims on to you, our honest policy holder, we are strongly committed to investigating claims. All cases of fraud will be reported to the Police and can also result in civil action by the insurers.

## your declaration

I/we declare that all statements and particulars stated on this form and all documents submitted are true and correct. I/we have not withheld any material information connected with this claim that will inhibit the insurers ability to make a fair and reasonable assessment of my claim.

I/we assign to insurers all rights of recovery/salvage against any person or organisation and will cooperate to secure such rights.

I/we acknowledge that the underwriter or it's agents may give to and obtain from any other insurer or insurance reference bureau, information relating to this or any other insurance held by me/us, or any claim made by me/us and I also authorise any other insurer to provide information relating to this or any claim made by me.

Your name      Your name  
     

Signature      Signature  
     

Date      Date

## please tell us what happened in as much detail as possible

Date of incident	Time	Country	Location
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> am/pm	<input type="text"/>	<input type="text"/>

Explanation (Please attach a letter if more space is required)

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### Person whose state of health caused the claim

Surname	First name
<input type="text"/>	<input type="text"/>

Date of birth	Relationship of that person to you
<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

Has the illness/injury occurred before? Yes  No

If **Yes**, please give details

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Was the person hospitalised? Yes  No

Date and time admitted

Date you discovered you could not continue with the trip as planned

Date you advised your travel agent to cancel/amend your trip

Has the illness/injury occurred before? Yes  No

If **No**, please explain the reason why?

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How many people in your travelling party?

How many people have cancelled their trip as a result of this incident?

Please give details

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## medical authority

To be completed by the person whose state of health caused the claim or the Executor of the Estate, if applicable

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for the condition/s which result in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original.

Surname	First name	Date of birth	Signature
<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

Name of usual doctor in the UK	Doctor's phone	Doctor's fax
<input type="text"/>	<input type="text"/>	<input type="text"/>

Explanation (please attach a letter if more space is required)

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## details of the amount claimed

To be completed by your travel agent\*

**NB:** Failure to supply the required documentation will result in the delay of the claim process.

	Name of supplier	Amount paid	Cancellation costs	OR	Amendment costs
			Amount refunded by supplier	Cancellation costs	
Flights (excluding taxes)			-	=	
			-	=	
			-	=	
Flight taxes			- Fully refundable by the airline	=	£0
			-	=	
Packages			-	=	
			-	=	
			-	=	
Accommodation, car hire, rail passes etc.			-	=	
			-	=	
			-	=	
	<b>TOTAL</b>				

### IMPORTANT: REQUIRED DOCUMENTATION

Please supply an Itinerary/Tax Invoice showing the breakdown of the flight fare and taxes.

Include a copy of the original itemised invoice, showing all arrangements booked.

Include a copy of the refund advice/invoice showing the amount charged and amount refunded.

Include copies of the booking conditions showing published cancellation penalties.

If a flight or any vouchers etc are 100% non-refundable, the original tickets or vouchers must be sent with your claim form.

### To be completed by your travel agent (if applicable):

I certify that the information stated on this form is true and correct.

Travel consultant's name

Travel consultant's signature

Travel agency store name and address

Date

Phone

Fax

Email address

## documentation we require to process your claim

Please check your claim and before you send it to us please ensure that you attach the following ORIGINAL documents:

Attached (Please tick)

### ALL CLAIMS

- Your original travel itinerary, travel tickets, booking invoice to confirm travel.
- A copy of your Certificate of Insurance.

### CANCELLING AND CUTTING YOUR TRIP SHORT

- The published booking conditions which support the amount (from each operator if applicable) that you are claiming.
- If non-refundable, we require the original tickets and vouchers.
- A copy of the original itemised invoice your travel agent/travel provider issued to you.
- The relevant part of the claim form completed by your travel agent (where your trip was booked with a travel agent) or if you booked independently.
- The Medical Authority must be completed by the person whose state of health caused the claim or the Executor of the Estate. If required, we will write to the doctor directly to request further information to assess your claim.

- If the trip was cancelled due to illness, injury or death of the policy holder, a Relative or Business Associate, you must also have that person's USUAL general medical practitioner complete the MEDICAL CERTIFICATE.
- If the claim is due to death a full copy, not an extract, of the Death Certificate is required (must state the cause of death).
- Confirmation you checked in at or before the recommended time.

**Please include any other documentation you wish us to consider.**

**If you have not provided any of the required documents please tell us the reason why in writing.**

## additional information

Please write any further details here or attach a letter if more space is required.


## office use only


# medical certificate

To be obtained at the claimant's expense from the patient's usual doctor in all cases of Amendment or Cancellation Costs resulting from accident, illness or death

**IMPORTANT:** The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries. The claimant is responsible for any fee imposed. **\*\* PLEASE USE BLOCK LETTERS \*\***

1. Full name of patient

Date of birth

2. Patient's relationship to claimant

3. Are you the patient's usual GP?

Yes  No

If **Yes**, for how long?

If **No**, please provide full details of the patient's usual GP

4. a Please give a precise diagnosis of the illness, injury or cause of death. If an injury, how was it sustained?

b If due to a pregnancy, on what date was the pregnancy confirmed?

c How many weeks pregnant was the person on this date?

d Was the conception medically assisted?

Yes  No

e Have there been complications with this or any other pregnancy?

Yes  No

f Expected delivery date

5. Date of onset of illness, injury or date of death

6. Date on which you were first consulted in relation to this

7. Date referred to specialist

8. Date tests prescribed and carried out

9. Date results advised to patient

10. Date there was a deterioration

11. Name and address of specialist/surgeon

12. Have you or anyone else previously treated the patient in respect of the same/similar/related illness or injury as described in question 4?

Yes  No

If **Yes**, state if same illness or injury, or specify similar/related illness or injury (please give full details including dates)

13. Was the patient advised to continue this treatment and/or medication

- Until departure on this journey Yes  No   
■ Whilst on this journey Yes  No

14. Was the patient hospitalised?

Yes  No

If **Yes**, advise admission date

15. a Please provide details of the patient's health at the time when the insurance was issued and the likelihood of the patient's health causing a claim (see claimant for exact date)

b Was the patient being treated for the condition which caused the cancellation or curtailment at or prior to the date the insurance was issued?

Yes  No

16. Was the patient on a waiting list for admission to hospital?

Yes  No

If **Yes**, please state

Date they were on the waiting list

Date of admission

17. Was it reasonable of the claimant to continue with travel plans considering the answer to the other questions?

Yes  No

18. Are you prepared to certify that solely due to the condition described in question 4, the claimant/s was/were required to cancel or curtail the travel arrangements?

Yes  No

**THE FOLLOWING QUESTIONS ONLY APPLY IF THE PATIENT WAS IN THE TRAVELLING PARTY**

19. Date it became apparent the patient would not be able to travel (if applicable)

20. How long was or will the patient be prevented from travelling?

from  to

21. Had the patient planned to travel against your prior advice? Yes  No

If **Yes**, please give details

22. Did the patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment?

Yes  No

If **Yes**, please give details

**I certify that the statements contained in this Medical Certificate are true and correct.**

Doctor's name

Doctor's signature

Date

Qualification

Phone

Fax

Address

Company stamp