

Travel Delay, Missed Departure, Cancellation or Curtailment Claim Form

INSTRUCTIONS - IMPORTANT - PLEASE READ CAREFULLY

1. Please answer all questions in FULL and in BLOCK -CAPITALS
2. Once fully completed, this form with original documents (not copies) in support of your claim with the original booking invoice should be forwarded to the Scheme Administrator this insurance, who are; Jubilee Service Solutions Ltd, 21 Perrymount Road, Haywards Heath, West Sussex, RH16 3TP

To help prevent fraud, insurers sometimes share information and details of your claim may be exchanged between other insurers. If any claim under this insurance is fraudulent or if any misleading or fraudulent means are used by you or anyone acting on your behalf to obtain benefit under this insurance, your right to any benefit under this insurance will end, your policy will be cancelled and the insurer will be entitled to recover any benefit paid and costs incurred as a result of any such fraudulent or misleading statement. The insurer may also inform the police.

SECTION A - to be completed by YOU for all claims

Certificate/ Policy Number:	<input style="width: 100%;" type="text"/>	Title:	Mr/Mrs etc <input style="width: 100%;" type="text"/>
Surname:	<input style="width: 100%;" type="text"/>	Date of Birth:	<input style="width: 100%;" type="text"/>
First Name(s):	<input style="width: 100%;" type="text"/>	Home Telephone:	STD <input style="width: 100%;" type="text"/>
Address:	<input style="width: 100%; height: 40px;" type="text"/>	Nature of Occupation:	<input style="width: 100%;" type="text"/>
Post Code:		Date of Booking:	<input style="width: 100%;" type="text"/>
Scheduled Date of Outward Travel:	<input style="width: 100%;" type="text"/>	Scheduled Date of Outward Travel:	<input style="width: 100%;" type="text"/>

Where the terms of your cover allow, claims payments may be made directly into your bank account. Please give us details of the account you would wish to be credited.	Your Bank Sort Code:	<input style="width: 100%;" type="text"/>
	Your Bank Account Number:	<input style="width: 100%;" type="text"/>

SECTION B - to be completed by YOU for TRAVEL DELAY & MISSED DEPARTURE claims

We will require from you the following:

1. All original receipts for expenses
2. For Travel Delay claims, a letter from the transport authority confirming the length and reason for the delay.
3. For Missed Departure, a letter as in 2 above and/or a letter from a garage giving details of the vehicle breakdown.

Scheduled DEPARTURE Date & Time:	<input style="width: 100%;" type="text"/>	When did you become aware of possible delay:	<input style="width: 100%;" type="text"/>
Actual DEPARTURE Date & Time:	<input style="width: 100%;" type="text"/>	How did you travel to International Departure:	<input style="width: 100%;" type="text"/>

Additional Expenses - Missed Departure Claims only.

Date	Description	Supplied By	Currency Amt	UK£ Equivalent	Paid Y/N

SECTION C - to be completed by YOU for CANCELLATION claims

We will require the following:

1. The original holiday cancellation invoice and any unused travel or flight tickets
2. If cancellation is due to illness, the medical certificate in Section E of this form
3. If cancellation is due to death, the medical certificate in Section E of this form together with a certified copy of the death certificate
4. If cancellation is due to redundancy, your official notification of redundancy.
5. If cancellation is due to other reasons, independent written evidence confirming such reason.

Date & Time you first became aware of the need to cancel:

Name of organisation and person who advised you:

Name of person causing cancellation:

If such person not booked to travel, relationship to you:

Please provide names and ages of all those cancelling:

Please give the following information about the sum claimed:

Total paid to Agent or Operator (excluding insurance)	£	<input style="width: 90%; height: 15px;" type="text"/>
Payment Method		<input style="width: 90%; height: 15px;" type="text"/>
Cancellation charges	£	<input style="width: 90%; height: 15px;" type="text"/>
Refund provided	£	<input style="width: 90%; height: 15px;" type="text"/>
Amount Claimed	£	<input style="width: 90%; height: 15px;" type="text"/>

SECTION D - to be completed by YOU for CURTAILMENT claims

We shall require from you the following:

1. All unused travel tickets
2. If curtailment is due to illness of a person at home, the medical certificate is Section E of this form.
3. If curtailment is due to illness of a member of the party a medical certificate from the overseas doctor confirming the necessity to return home.
4. If curtailment is due to death, the medical certificate in Section E of this form together with a certified copy of the death certificate.
5. If curtailment is due to other reasons, independent written evidence confirming such reason.

Date of early return home:

Number of nights booked & number of nights unused:

Name of person causing curtailment:

If such person was not booked to travel, their relationship to you:

Please provide names and ages of all those curtailing:

Please advise whether the travel arrangements differed from the original booking:

Please provide a description of the circumstances giving rise to the claim:

Did you use the emergency telephone number?

Yes No

If so on what date?

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**SECTION E - MEDICAL CERTIFICATE to be completed by the patient's usual GP or the TREATING DOCTOR
CANCELLATION or CURTAILMENT claims**

Any change made by the doctor for completion of this form is your responsibility.
Instructions to your doctor - please complete this section in BLOCK CAPITALS

Patient's Name & Address:

Date of Birth:

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How long has the patient suffered from this condition?:

Diagnosis

Date patient first sought attention for this condition:

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Please give medical history relating to this condition. If appropriate, state NONE.

At the time the holiday was arranged were you aware of any medical condition that may have led to the travel plans being cancelled or curtailed? If appropriate state NONE.

In your opinion was it medically necessary for the holiday to be cancelled or curtailed and if so, on what date was the patient advised?

What condition has led you to advise against travel?

If the claim relates to pregnancy please advise:

Date pregnancy confirmed:

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DOCTOR'S OFFICIAL STAMP

Estimated confinement date:

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DOCTOR'S SIGNATURE:

DOCTOR'S NAME (BLOCK CAPITALS):

Date:

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SECTION F - to be completed by the PATIENT

To be completed by the patient whose disability has resulted in the claim being made.

CONSENT TO OBTAIN A MEDICAL REPORT

Please read the following wording; "Access to Medical Reports 1988 - Your rights Explained" before completion.

I have been informed of my statutory rights under the Access to Medical Reports Act 1988 and, in connection with my insurance claim hereby consent to Jubilee Service Solutions Ltd seeking medical information from any doctor who at any time has attended me concerning anything which affects my mental or physical health, and I agree that a copy of this consent has the validity of the original. If it should be necessary for the Scheme Administrators to approach my doctor for a medical report:

* I DO NOT WISH TO SEE THE MEDICAL or * I DO WISH TO SEE THE MEDICAL REPORT (*delete as appropriate)

Patient's Signature:

Date:

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NOTE: Access to medical reports will facilitate the fair and accurate assessment of your claim. If you wish to see the medical report this may delay consideration of your claim.

ACCESS TO MEDICAL REPORTS ACT 1988 - YOUR RIGHTS EXPLAINED

Before we can apply for a medical report from a doctor who has cared for you, we need your consent. Before doing so, however, you should read this carefully, as it sets out your rights under the Access to Medical Reports Act 1988 and the procedures for dealing with reports. You do not have to give your consent, but if you do, you can say whether or not you wish to see the report before it is sent to the Scheme Administrators. If you do not give your consent, we may be unable to process your claim.

If you wish to see the report, we will tell you at the same time as we write to the doctor, and we will tell your doctor you wish to see the report. You will then have 21 days to contact the doctor about arrangements for you to see the report. Of course, the quicker you act, the quicker your claim will be considered.

Whether or not you wish to see the report, he can charge you a reasonable fee to cover his costs.

Once you have seen the report, the doctor cannot submit it to us until he has your consent. You can write to the doctor, asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your view on any part where you and the doctor are not in agreement, and the doctor is not prepared to alter.

The doctor is not obliged to let you see any part of the report if in his opinion it would be likely to cause serious harm to your physical or mental health, that of others, would indicate the doctor's intentions towards you, or if disclosure would be likely to reveal information about, or the identity of another person who has revealed information about you, unless that person has consented to or the information relates to, or has been supplied by a health professional involved in caring for you. In such cases, the doctor must notify you and you will be limited to seeing any remaining part of the report. If it is the whole report which is affected, he must not send it to us unless you give your consent.

SECTION G - DECLARATION to be signed by YOU for ALL claims

I declare that to the best of my knowledge and belief, the answers given above are true and I understand that if I have knowingly made a false representation any payments shall be invalidated.

I consent to the seeking of information from other insurers to check the answers I have provided and I authorise the giving of such information for such purposes. I understand that in the event of a third party being liable for the accident or illness all rights are subrogated to Jubilee Service Solutions Ltd for settlement of the claim. I confirm that I hold no other insurance covering this loss and no claim has been submitted to any other insurer.

Claimant's Signature:

Date:

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