



CLAIM No:- \_\_\_\_\_  
For Office Use Only

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## Cancellation – Claim Form

OSG Travel Claims are committed to providing a quality service. In order for us to assist you as quickly and efficiently as possible, it is important that you provide all necessary documentation.

**If a claim is received without the correct documentation or the claim form has not been fully completed, this can delay your claim.**

IMPORTANT – Insurers require ORIGINAL documents. You must provide, at your own expense, any documents required to process your claim. **We strongly recommend that you keep copies of all documents forwarded to us.**

### **Documentation Required :- Failure to provide can result in our being unable to process your claim**

Please tick to confirm you have attached the following documents [Tick]

<b>Fully Completed Claim Form</b>	Complete each section. Do not use N/A.	<input type="checkbox"/>
<b>Confirmation of Insurance</b>	Insurance/Validation Certificate. In the case of credit card Insurance policies, please forward your credit card statement showing payment of the trip / holiday.	<input type="checkbox"/>
<b>Confirmation of Trip Dates</b>	Tour Operators Confirmation Booking invoice. Also Forward any travel tickets you may have or any other documents issued as evidence of the trip.	<input type="checkbox"/>
<b>Cancellation Details</b>	Cancellation invoice from the Travel Agent or Tour Operator. Any unused flight tickets or confirmation of any refunds given to you. Cancellation invoice for any accommodation. These documents <u>must</u> detail all cancellation charges incurred that you are claiming for.	<input type="checkbox"/>
<b>Completed Medical Certificate</b>	The medical certificate enclosed must be completed by the usual medical practitioner of the person whose condition gave rise to the claim. This is <u>also</u> required in the event of death.	<input type="checkbox"/>
<b>Death Certificate</b>	Please forward death certificate if appropriate. Please note, the medical certificate will <u>also</u> have to be completed.	<input type="checkbox"/>
<b>Redundancy</b>	If the claim is as a result of redundancy, please forward a letter from your employers confirming date of notification of redundancy.	<input type="checkbox"/>
<b>Cancelled Flight (Abandonment)</b>	If the claim is due to abandonment after the cancellation of your outgoing flight, forward written confirmation from the airline confirming the cancellation of the flight, the reason, and when the next available flight was due to depart.	<input type="checkbox"/>
<b>Any Additional Information/documentation</b>	Any additional information or documents which you wish to enclose to substantiate your claim	<input type="checkbox"/>

We understand that it can at times be a daunting prospect making a claim. Please help us to help you by following these guidelines.

- Always send original documentation (We recommend you retain copies)
- Make sure that the claim form is fully completed, and that the information given is as clear as possible
- Always provide the information requested above. If for some reason, the documentation is not available, please attach a letter advising why it has not been enclosed.

OSG Business Solutions – Travel Claims

## Cancellation – Claim Form Continued

Our aim is to process your claim as efficiently as possible. In order to achieve this please ensure that you fully complete the form and provide the original documents requested on the Information Sheet. **(We strongly recommend you retain copies). Please note – if the information requested is not supplied, this can hold up your claim, and we may not be able to process it.**

**NB. All sections MUST be FULLY completed. (In BLOCK CAPITALS please)**

Name of Policy Holder (include Mr/Mrs/Ms etc)	<input style="width: 95%;" type="text"/>	Age	<input style="width: 95%;" type="text"/>
Name of Person to whom any payment should be made payable to - If different from above	<input style="width: 95%;" type="text"/>	Address	<input style="width: 95%; height: 40px;" type="text"/>
What Insurance Company Did You Take your Travel Insurance Out With?	<input style="width: 95%;" type="text"/>		
What Is Your Policy Called / Credit Card Type?	<input style="width: 95%;" type="text"/>	Post Code (If Applicable)	<input style="width: 95%;" type="text"/>
Policy / Certificate Number If Credit Card Please write the Number (first 7 and last 4 digits only please)	<input style="width: 95%;" type="text"/>	E-Mail address	<input style="width: 95%;" type="text"/>
Policy Issue Date	<input style="width: 95%;" type="text"/>	Incident Date	<input style="width: 95%;" type="text"/>
Home Telephone Number	<input style="width: 95%;" type="text"/>	Mobile Telephone Number	<input style="width: 95%;" type="text"/>
Country of Destination	<input style="width: 95%;" type="text"/>	Travel Agent	<input style="width: 95%;" type="text"/>
Departure Date	<input style="width: 95%;" type="text"/>	Booking Date	<input style="width: 95%;" type="text"/>
Original Return Date	<input style="width: 95%;" type="text"/>	Actual Return Date	<input style="width: 95%;" type="text"/>
Tour Operator	<input style="width: 95%;" type="text"/>	Occupation	<input style="width: 95%;" type="text"/>

### Data Protection

In order to administer your claim, the information provided in this form may be held on computer and/or in manual files for administration and risk assessment purposes. We may disclose your personal data to and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes. By returning this form, you consent to our processing your personal data for the above purposes.

### Claimants signature and declaration

- I declare to the best of my knowledge all particulars in this form are true and accurate, with no omissions of any material information which would affect the insurers assessment of this claim
- I give permission for any medical practitioner, Police or similar authority mentioned with respect to this claim to release information regarding my records.
- I am aware that it is a criminal offence to defraud or attempt to defraud an insurer and that by doing so I may be prosecuted. I am also aware that should any element of this claim be found to be fraudulent in any way, all elements of the claim will be denied.
- I grant OSG Business Solutions and the Insurers they represent, full rights of subrogation in respect to any payments made on my behalf. I further agree to fully co-operate with such recovery efforts that Insurers deem necessary.

Signed

Date

## Cancellation – Claim Form Continued

Details of all insured people included in this claim

Forename	Surname	Age

Date of cancellation \_\_\_\_\_

Please state if the cancellation was due to illness, injury or death \_\_\_\_\_

Name and age of person who gave rise to this claim \_\_\_\_\_, \_\_\_\_\_

Relationship of this person to the insured \_\_\_\_\_

The Condition which resulted in the cancellation \_\_\_\_\_

Did you contact Medical Health Check to declare the details of the above condition?      **YES / NO**

If Yes, please advise reference number \_\_\_\_\_

Explain in full why trip was cancelled \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Total amount paid for Trip, excluding premium (Travel & accommodation)	
Cancellation Charge	
Amount Refunded	
Amount Claiming (less any refunds given)	

Was this trip covered under any other insurance? **YES / NO**

If Yes, please provide details \_\_\_\_\_

Please remember to include all ORIGINAL documentation requested on the information sheet:- (Please retain copies for your records)

**Confirmation of Insurance, Booking invoice, Cancellation Invoice, Flight Tickets, Medical Certificate.**

**For cancellation due to non medical reasons, provide:-**

**Redundancy:-** A redundancy notice showing that you have been made redundant under applicable legislation and the date you were made aware of redundancy

**Burglary, fire, storm or flooding to your home:-** a letter from the police confirming that the incident occurred

**Jury Service:-** Letter from the courts showing the date on which you were made aware that you must attend for jury service or as a witness in court.

## Medical Certificate – Cancellation

**This section must be completed fully by the usual G.P. of the person whose death, injury or illness gave rise to the claim, whether travelling or not. This form is not valid unless it bears the relevant surgery / hospital stamp.**  
Any expenses for the completion of this form are at the insured's expense.

Please complete all sections fully using **BLOCK CAPITALS**.

**Claimant – please complete questions 1, 2 & 3 prior to giving to the medical practitioner.**

1. Patients Name \_\_\_\_\_ 2. Booking Date \_\_\_\_\_ 3. Date of issue of insurance \_\_\_\_\_

4. Age \_\_\_\_\_ 5. Are you the patients usual Doctor? YES / NO How long for \_\_\_\_\_

### 6. Details of the medical condition giving rise to the claim:

Diagnosis / Condition \_\_\_\_\_ Date of Diagnosis \_\_\_\_\_

Date of first attendance for this condition \_\_\_\_\_ Date which cancellation was recommended \_\_\_\_\_

7. Was your patient referred to a consultant, specialist or hospital within :-

- a. 24 months of the purchase of insurance or the booking of the trip **YES / NO**
- b. 18 months of the purchase of insurance or the booking of the trip **YES / NO**
- c. 12 months of the purchase of insurance or the booking of the trip **YES / NO**

If YES, please provide full details including dates, condition, prescribed medicines, any follow up action

\_\_\_\_\_

8. Was your patient placed on a waiting list, either for treatment or investigation within 12 months of the purchase of insurance or the booking of the trip? (See question 2). **YES / NO**

If YES, please provide full details including dates of referral & Procedure and condition.

\_\_\_\_\_

9. Was your patient suffered from or received any form of medical advice, treatment, or medication within the past 18 months for :

- Heart or circulatory related condition (e.g. hypertension, angina, stroke)**
- A lung or breathing related condition**
- Any form of cancer**

If YES, please provide full details including dates, condition, prescribed medicines, any follow up action.

\_\_\_\_\_

10. Has your client received a terminal prognosis? **YES / NO**

If YES, Date of prognosis \_\_\_\_\_ Date when condition or related condition first arose \_\_\_\_\_

11. If your patient is now deceased, was there any pre-existing condition that was a contributory factor to the cause of death. **YES / NO** IF YES, please elaborate \_\_\_\_\_

12. If the claim concerns pregnancy, please state

- a. Date pregnancy confirmed by Doctor \_\_\_\_\_
- b. Expected or actual date of confinement \_\_\_\_\_
- c. What condition associated with the pregnancy has led you to advising against travel

d. Has your patient had any complications in a previous pregnancy **YES / NO** Date \_\_\_\_\_

### DECLARATION

I have examined the above and/or referred to the relevant medical records and declare the details are accurate and correct and that no material facts have been omitted. **OFFICIAL OFFICE STAMP**

Signed \_\_\_\_\_ Print Name \_\_\_\_\_

Date \_\_\_\_\_