**CLAIM No :-**_____
For Office Use Only

**OSG Travel Claims,**
**PO Box 1086, Belfast, BT1 9ES**
**Email : info@osgtravelclaims.co.uk**
**Tel: 020 7581 6444**

# Curtailment (Early Return Home) – 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] |
|---|---|---|
| **Fully Completed Claim Form** | Complete each section. Do not use N/A. | |
| **Confirmation of Insurance** | Insurance/Validation Certificate. In the case of credit card Insurance policies, please forward your credit card statement showing payment of the trip / holiday. | |
| **Confirmation of original trip dates** | Tour Operators Confirmation Booking invoice – this should also include a breakdown of travel and accommodation costs. Please forward original travel tickets you may have and any other documents issued as evidence of the trip. | |
| **Additional Expenses** | Receipts for additional expenses incurred, along with any new flight tickets and confirmation flight booking. | |
| **Completed Medical Certificate**<br><br>**(To be completed ONLY if the 24 hour Medical Assistance Company was not contacted or did not authorise the curtailment.)** | The medical certificate enclosed must be completed by the usual medical practitioner of the person whose condition gave rise to the claim. This is also required in the event of death. If the assistance company was not contacted or did not authorise the curtailment, please provide written confirmation from the treating medical practitioner of the necessity to curtail the trip. Also provide a full written explanation as to why the assistance company was not contacted. | |
| **Death Certificate** | Please forward death certificate if appropriate. Please note, the medical certificate will also have to be completed. | |
| **Any Additional Information/documentation** | Any additional information or documents which you wish to enclose to substantiate your claim. | |

**We understand that it can at times be a daunting prospect when 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**

# Curtailment (Early Return Home) – 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) | | Age | |
| Name of Person to whom any payment should be made payable to - If different from above | | Address | |
| What Insurance Company Did You Take your Travel Insurance Out With? | | | |
| What Is Your Policy Called / Credit Card Type? | | Post Code (If Applicable) | |
| Policy / Certificate Number If Credit Card Please write the Number (first 7 and last 4 digits only please) | | E-Mail address | |
| Policy Issue Date | | Incident Date | |
| Home Telephone Number | | Mobile Telephone Number | |
| Country of Destination | | Travel Agent | |
| Departure Date | | Booking Date | |
| Original Return Date | | Actual Return Date | |
| Tour Operator | | Occupation | |

## 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

# Curtailment (Early Return Home) – Claim Form Continued

Details of all people included in this claim

| Forename | Surname | Age |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Actual Date of early return _____

Please state briefly why the trip was cut short

_____
_____
_____

Name and age of person who illness or injury gave rise to this claim_____, _____

Relationship of this person to the insured _____

Condition which resulted in the curtailment_____

Did you contact Medical Health Check to declare the details of the above condition when you purchased the insurance? If Yes, please advise reference number_____

Did you contact the 24 hour medical assistance company at the time of the incident? **YES / NO**
If Yes, please state their reference number and the advice they gave. Did they authorise the early return home?

_____
_____

If No, please advise why not. _____
_____

| | |
|---|---|
| **Total amount paid for Trip (Travel & accommodation)** | |
| **Amount Refunded** | |
| **Number of full days unused** | |

In the table below, please detail all extra travel and accommodation expenses incurred which you are claiming.

| Item Number | Date Expense Incurred | Description of expense (Include full details, i.e. full flight details 'from – to') | Name of Provider i.e. Hospital / Clinic / Airline etc. | Amount Claimed (include currency) | Receipts attached? YES / NO |
|---|---|---|---|---|---|
| 1 | | | | | |
| 2 | | | | | |
| 3 | | | | | |
| 4 | | | | | |

Is this trip covered under any other insurance (including Private Health Insurance?) **YES / NO**
If Yes, please provide details, or write 'None' and sign. _____

**Please remember to include all ORIGINAL documentation requested.** (Please retain copies for your records).
**Confirmation of Insurance, Booking invoice, Flight Tickets (Both original and new), Medical Certificate, receipts for all expenses.**
**For curtailment 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 – Curtailment

**To be completed if the 24 hour Medical Assistance Company was not contacted or did not authorise your curtailment**

**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 _____Was it medically necessary to curtail the trip **YES / NO**

If Yes, please advise why_____

7. Has your patient been 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. Has your patient been 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. Has 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 from a medical practitioner? **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 curtail your trip
    _____
    **d.** Has your patient had any complications in a previous pregnancy **YES / NO**
    ii. If YES, please elaborate

**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** _____