CLAIM No:-_____

Sedgwick OSG, Merrion Hall, Strand Road, Sandymount, Dublin 4, Ireland.
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Cancellation – Claim Form

Sedgwick OSG 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.

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. **IMPORTANT: IF YOU ARE PROVIDING YOUR CREDIT CARD STATEMENT, PLEASE ENSURE ONLY THE FIRST 6 AND LAST 4 DIGITS OF YOUR CREDIT CARD NUMBER ARE SHOWN**	
Confirmation of Trip Dates	Tour Operators Confirmation Booking invoice. Also Forward any travel tickets you may have or any other documents issued as evidence of the trip.	
Cancellation Details	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 must detail all cancellation charges incurred that you are claiming for.	
Completed Medical Certificate	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.	
Death Certificate	Please forward death certificate if appropriate. Please note, the medical certificate will also have to be completed.	
Redundancy	If the claim is as a result of redundancy, please forward a letter from your employers confirming date of notification of redundancy.	
Cancelled Flight (Abandonment)	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.	
Any Additional Information/documentation	Any additional information or documents which you wish to enclose to substantiate your claim	

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)		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 6 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	

We use personal information which you supply to us for administration, claims management and other insurance purposes, as further described in our Privacy Policy, available here: http://www.osg.ie/terms-conditions/

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 Sedgwick OSG 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.
- In the event of a third party being liable for the loss / damage, all rights of recovery pass to Sedgwick OSG Travel Claims on settlement of this claim.

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 _____