

Travel, Medical, Cancellation and/or Curtailment Claim Form

We recognise the need for prompt and careful handling of your claims. Please help us to help you by answering all relevant questions. Continue your answers on a separate page if necessary.

In addition you should:

- telephone us or your insurance advisor if you need assistance
- provide all documentation in support of your claim (although you should not delay in submitting this form in the event that the necessary documentation is not immediately to hand)

Please return the completed form to your insurance advisor or the claims department at the address below:

BROKER STAMP

HISCOX

PO Box 420 Sittingbourne ME10 1WB
Telephone: +44 (0)870 084 3776 Facsimile: +44 (0)20 7448 6923
Website: www.hiscox.com Email: 606pip.claims@hiscox.com



Travel, Medical, Cancellation and/or Curtailment Claim Form

Your Details

1. Policy/certificate holder:

2. Correspondence address:
Postcode:

3. Telephone number: Fax:

4. Email address:

5. Policy/Certificate number:

6. Date of booking:

7. Departure/return dates:

8. Destination:

9. Booking agent:

10. Address of booking agent:
Postcode:

Please provide a copy of the booking invoice.

Medical, Repatriation and other expenses claims

11. Date you were first aware of symptoms of illness or date of accident:

12. Nature of illness or details of accident: (Continue on a separate sheet if necessary)

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13. Have you previously suffered from the same illness? Yes No

If Yes, please give details:
(Continue on a separate sheet if necessary)

14. Details of injuries sustained:
(Continue on a separate sheet if necessary)

15. Are you a member of BUPA, PPP, WPA or similar association? Yes No

If Yes, please give details:
(Continue on a separate sheet if necessary)

16. Give details of any advance payments for accommodation and/or travel not used:
(Continue on a separate sheet if necessary)

Have you attempted to recover these payments? Yes No

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17. If illness resulted in a stay as an in-patient in a hospital, give dates admitted/discharged:

Admitted:	Discharged:
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18. List amounts being claimed:

Medical expenses	£
Hospital expenses	£
Additional hotel accommodation	£
Additional repatriation costs	£

Please attach all receipts or accounts to support your claim.

Trip cancellation and disruption claims

19. Please give:

a) the cost of travel:

b) the cost of accommodation:

c) the amount of deposit:

d) date final instalment due:

20. Amount being claimed:

a) Travel:

b) Accommodation:

21. Has the booking agent named in question 9 been notified?

 Yes No

If Yes, please provide all correspondence.

22. Give reasons why cancellation was necessary:
(Continue on a separate sheet if necessary)

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In the event that your claim is accepted and you would prefer us to pay funds straight into your account, please fill in the details below:

Payment to be made by: (please tick preference)

Direct transfer to the bank account below:

Name and Address of Bank:

Postcode

Account Name:

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Account Number:

--	--	--	--	--	--	--	--

Sort Code:

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Cheque made payable to you

Data Protection Act

By signing this Claim Form you consent to Hiscox using the information we may hold about you for the purpose of providing insurance and handling claims, if any, and to process sensitive personal data about you where this is necessary (for example health information or criminal convictions). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities. Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. The information provided will be treated in confidence and in compliance with the Data Protection Act 1998. You have the right to apply for a copy of your information (for which we may charge a small fee) and to have any inaccuracies corrected.

Declaration

I declare that the details given on this form are true and complete to the best of my knowledge.

Name

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Signature

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IF THE CANCELLATION OR DISRUPTION OF THE TRIP IS CAUSED BY INJURY OR ILL HEALTH THE FOLLOWING IS TO BE COMPLETED BY THE DOCTOR WHO ORIGINALLY TREATED THE PERSON WHOSE HEALTH CAUSED THE CANCELLATION OR CURTAILMENT, OR THAT PERSON'S REGULAR DOCTOR. THE EXPENSE OF THIS IS TO BE BORNE BY THE CLAIMANT.

1. Are you the patient's usual medical attendant? Yes No

If Yes, since when?

2. Date of onset of illness or accident:

3. Details of illness:
(Continue on a separate sheet if necessary)

4. Has the patient suffered from similar illness or injury before? Yes No

If Yes, please give details:

(Continue on a separate sheet if necessary)

I certify that the claimant was unable to travel on:

Signature

Qualifications:

Address:

Postcode:



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Registered in England and Wales
Number 70234

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Website: www.hiscox.com

For training and quality control purposes,
telephone calls may be monitored or recorded.

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