ROGER RICH & CO
CHARTERED LOSS ADJUSTERS

T: +44 (0) 1608 641351
F: +44 (0) 1608 641176
E: enquires@rogerrich.co.uk

CLAIM FORM FOR TRIP CANCELLATION, CURTAILMENT OR RE-ARRANGEMENT

(to be completed by the person who purchased the insurance)

SECTION 1 – YOUR DETAILS

Mr / Mrs / Miss Forename: ______________________ Surname: ____________________________

Address: ____

____

____ Postcode: ____________________________

Daytime telephone number: _______________________________________

Occupation:_________________________________ Date of Birth: _________________________

SECTION 2 – DETAILS OF YOUR TRIP

Date holiday was booked: ____________________________ Destination: ____________________

Date Deposit was paid for holiday: ______________________ How much paid?: £_______________

Date final balance was paid: ___________________________ How much paid? £_______________

Date Insurance purchased: ____________________________ How much paid? £_______________

Certificate/Policy Number: ____

Scheduled date of departure: ____________________ Schedule date of return: ________________

If you did not return on the scheduled date, what date did your return: ____________________

SECTION 3 – DETAILS OF YOUR CLAIM

Did you have to: cancel ( ) , curtail ( ) or re-arrange ( ) your trip – please tick as appropriate

Please give reasons for cancellation, curtailment or re-arrangement (use separate sheet if necessary)

____

____

____

____

Who did you notify of the above: ___________________________ and on what date ___________________

Please give name of person necessitating the cancellation, curtailment or rearrangement: ______________

Was the above named person due to travel / did travel with you?: ___________________________________

What is your relationship with the above named person?: ____

Please give the date of birth of the above named person: ____

If you had to curtail all or part of your holiday please state which parts were missed: _________________

____

____

____

Have you received any refunds in respect of your cancellation, curtailment or rearrangement from any Third Parties? Yes ( ) No ( )

If yes please give: Name of Third Party: ____

Amount refunded: £________________________

Date of Refund: ___________________________

Please state amounts being claimed and for what amounts are claimed:

Amount	Claimed for

(please use additional sheet if necessary)

BANK DETAILS (IF BACS TRANSFER OF SETTLEMENT IS ACCEPTABLE)

Account name: [ ] Account number: [ ]

Bank name: [ ] Sort Code: [ ]

SECTION 4 – DECLARATION

Important: Please read this declaration before signing. No claim will be paid unless the declaration is signed

I understand that the making of a fraudulent insurance claim is a criminal offence likely to lead to prosecution. I confirm that the information given on this claim form is, to the best of my knowledge and belief true in every respect and the amounts claimed have not been exaggerated, refunded to me or claimed from any other source.

Signature: ____ Date: ____________________________

DOCTOR'S REPORT

The claimant must at his or her own expense have the following certificate completed by a duly qualified medical practitioner.

This certificate relates to the person whose state of health caused cancellation, curtailment or rearrangement.

Name of person to whom these medical details apply: _____________________________________(Patient)

Date of Birth of the Patient: _______________________________

Are you the Patient's usual medical practitioner? YES ( ) NO ( ) (please tick as appropriate)

How long have you been treating the Patient? ____

When did you first treat or consult the Patient for the illness or injury which has occasioned the cancellation or curtailment? ___________________________________

Date of onset of illness or date of injury: ___________________________

Please give a brief account of the course and prognosis of the illness / injury: ________________________

____

____

Has the patient been included on a waiting list for in-patient treatment for this condition? YES ( ) NO ( )

If so please advise the date they were put on the list__________________

Has the Patient ever suffered from this or any similar or related condition? YES ( ) NO ( )

If YES please give full details: ____

____

At the time of booking the trip, was the patient taking any medication or under any treatment?

If YES, please supply full details____

____

Did the Patient consult you for permission to travel before booking the trip? YES ( ) NO ( )

Do you consider the patient was fit to travel at the time of booking the trip? YES ( ) NO ( )

Did you advise the patient to cancel the trip? ________________ If so please give date: ______________

Do you consider the cancellation, curtailment or rearrangement justifiable on medical grounds? YES ( ) NO ( )

If cancellation was due to pregnancy please give: Date of confinement: _______________________

Date pregnancy confirmed: _________________

General Remarks: (please use separate sheet if necessary)_____________________________________

DECLARATION

I have examined the patient and/or his medical records. I confirm that to the best of my knowledge the information given above is correct and that no details relevant to the case have been omitted.

Signed ____ Practice Stamp: (Please include address & telephone number if not on stamp)

Name ____