Missed Event Insurance
Claim Form

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Dear Claimant,

Please complete this form in full and return to:

Mayday Travel Claims
2 Clifton Mews
Clifton Hill
Brighton
East Sussex
BN1 3HR

Or email: **claims@maydaytravelclaims.com**

Please ensure all relevant sections are completed and the supporting documentation is attached. This will enable us to assess your claim quickly.

WE RECOMMEND THAT YOU KEEP A COPY AND SEND THE COMPLETED CLAIM FORM BY RECORDED DELIVERY.

WE WILL CONTACT YOU WITHIN 5 WORKING DAYS OF RECEIPT OF THE CLAIM FORM.

WE RESERVE THE RIGHT TO REQUEST THAT ORIGINAL RECEIPTS / REPORTS OR ANY OTHER DOCUMENTATION BE SUBMITTED IN ORDER TO SUBSTANTIATE THE CLAIM.

DOCUMENT CHECKLIST (Please tick accordingly)

	✓
Original Ticket (or barcode for the Ticket if it is an electronic Ticket) and supporting documentation	
Certificate of Insurance must be supplied with your claim	

If any part of your claim is of a dishonest nature, then your claim will be denied and will be referred the appropriate authorities.

PERSONAL DETAILS

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other Date of Birth DD/MM/YYYY

Surname First name

Certificate of Insurance/ Policy Number

Address

Post code

Please tick your preferred method of contact

☐ Email ☐ Post ☐ Mobile ☐ Telephone

Telephone Mobile

Email Occupation

EVENT DETAILS

Name of event Place of Event/Venue

Date of event DD/MM/YYYY Date of purchase DD/MM/YYYY

Time of event HH:MM

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CLAIM INFORMATION

In this section we will ask you the circumstances of your claim and the amount that you are claiming. Please tick the applicable box(es) relating to your claim and answer all sections.

A. Ticket and payment details

Number of tickets		Total amount claimed		Cost per ticket		Amount of refund received	

*Ticket cost excluding any transaction fee

Please answer all questions relating to what is being claimed, otherwise we will be unable to process your claim

B. Details of companion(s)

Insert details of companion(s)/intended recipients of Ticket(s) if any claim is made for used Ticket(s) you purchased for someone else. If there is not enough room in the space provided, please continue details of companions on a separate piece of paper.

Name of companion	
Address	
Postcode	
Name of companion	
Address	
Postcode	

C. Reason for claim for payment of Ticket cost

PLEASE TICK APPROPRIATE BOX

☐	Injury or Sickness of you or your Companion	Certificate of Doctor/Dentist**
☐	Injury or Sickness of a Relative	Certificate of Doctor/Dentist**
☐	Death of you or your Companion	Death certificate
☐	Death of a Relative	Certificate of Doctor/Dentist** and death certificate
☐	Transport accident causing bodily injury	Report from Police/official body & certificate of Doctor/Dentist**
☐	Vehicle breakdown within 48 hours prior to event	Letter report from the repair service or public transport provider
☐	Transport cancellation/delay/shortening/diversion because of strike, riot, hijack, civil protest, weather or natural disaster	Letter/report from the transport provider
☐	Home/place of business rendered uninhabitable by fire, explosion, weather, natural disaster, burglary or vandalism	Letter/report from Police, Fire Brigade or household/business Insurer
☐	Assault causing bodily injury	Police report
☐	Jury duty	Letter from the court
☐	Military orders	Letter from Commanding officer
☐	Redundancy from full-time employment	Letter from employer

****If your claim arises from Injury or Sickness of you, your Companion or a Relative, or death of a Relative, a completed Medical Certificate is required (See page 5). Please note: We Reserve the right to request reports or any other documentation be submitted in order to substantiate the claim.**

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D. Documents

THE FOLLOWING DOCUMENTS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance
2. Original unused Ticket (or barcode if it is an electronic Ticket)
3. Supporting documentation if your claim arises from injury or Sickness of you, your Companion or a Relative, a completed Medical Certificate is required (see page 5 of Claim Form)

FAILURE TO PROVIDE ALL NECESSARY EVIDENCE AND DETAILS MEANS WE WILL BE UNABLE TO PROCESS YOUR CLAIM

E. Claim Details

Date on which you were aware that you/Companion would not be able to attend the event

Date of event DD/MM/YYYY

Please tell us in as much detail as possible about the circumstances giving rise to your or Companion's inability to attend the Event. Be as specific as possible. If there is not enough room in the space provided, you may continue your description on a separate piece of paper.

F. Injury or Sickness Claim

Type of injury or or Sickness

Date of injury or Commencement of Sickness DD/MM/YYYY

If injury – Give details of injury

Date of First Medical/Dental Consultation DD/MM/YYYY

Name of Doctor, Dentist and/or Hospital

Details of other treatment by Doctor, Dentist and/or Hospital

Dates in Hospital - Admitted DD/MM/YYYY Time HH:MM

Discharged DD/MM/YYYY Time HH:MM

If your claim arises from Injury or Sickness of a Relative, or death of a Relative, has the person ever suffered from the same or similar Injury or Sickness in the past? ☐ Yes ☐ No

If Yes, please give details including dates, names and address of treating physicians

Name and Address of usual family doctor

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MEDICAL AUTHORITY AND DECLARATION

I DECLARE THAT:

- I will use my best endeavours and render all reasonable assistance and co-operation to Mayday Travel Claims for the assessment of my claim;
- The information supplied by me is true and correct and I have not withheld any information likely to affect the assessment of my claims;
- I understand that the claim may be denied, if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that, by investigating my claim or by accepting proofs of my claim, Mayday Travel Claims has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy;
- A photocopy of this Authorisation shall be considered as effective and valid as the original and I specifically authorise its use as such.

I appoint Mayday Travel Claims to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for (at any time);
- my Health Insurance claim history, including Medicare;
- any information from third persons who may have information relevant to my eligibility to receive a benefit.

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Signature of Claimant		**Date**	DD/MM/YYYY
Name of Claimant			
Signature of Witness		**Date**	DD/MM/YYYY
Name of Witness			

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MEDICAL CERTIFICATE

To be completed by the patient's usual Doctor/Dentist (at the claimant's expense) for all claims arising from injury or Sickness of you, your Companion or a Relative, or death of a Relative.

Name of person to whom this certificate applies (i.e. the person whose state of health cause of the claim):

Date of birth DD/MM/YYYY

Address

Post code

Instructions to the Medical Professional:

Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Ticket Insurance Claim

1 a) Are you the patient's usual medical practitioner? ☐ Yes ☐ No If **Yes** how long?

b) If **No**, do you have access to their medical records? ☐ Yes ☐ No

The claimant must indicate (by ticking the relevant box) which is applicable, question 2 or 3.

2a) Did you recommend that the patient not attend the Event due to the patient's state of health? ☐ Yes ☐ No

b) On what date did you make this recommendation? DD/MM/YYYY

c) Please give precise details of the nature of the Injury or Sickness which gave rise to this recommendation (including the final diagnosis)

d) On what date were you first made aware of the condition, or change in the condition? DD/MM/YYYY

OR

3a) Did you recommend that the primary care of the patient was necessary due to the patient's state of health? ☐ Yes ☐ No

b) On what date did you make this recommendation? DD/MM/YYYY

c) Please give precise details of the nature of the Injury or Sickness which gave rise to this recommendation that primary care be provided, or (ii) the patient's death.

d) Is there any indication that the Injury or Sickness arises from alcohol or substance abuse, or is a physical complication related to alcohol or substance abuse? ☐ Yes ☐ No

e) On what date did the patient first become aware of their symptoms? DD/MM/YYYY

f) Please describe the symptoms advised by the patient.

g) On what date were you first made aware of the condition, or change in the condition? DD/MM/YYYY

h) Has the patient previously been investigated, diagnosed or treated in respect to the same/similar/related Injury or Sickness? ☐ Yes ☐ No

If **Yes**, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

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I certify that the statement contained in this Medical Certificate are true and correct.

Doctor's Signature

Date DD/MM/YYYY

Doctor's Stamp

PLEASE NOTE: We cannot process your claim if you do not supply the listed documentation with your fully completed and signed form

I HAVE READ AND UNDERSTOOD THE DECLARATION ABOVE AND INCLUDE THE NECESSARY DOCUMENTS TO SUBSTANTIATE MY CLAIM

Claimant(s) full name(s)

Claimant's signature

Date DD/MM/YYYY

Would you like a third party to act on your behalf? ☐ Yes ☐ No

I / we authorise _____ to act on my behalf in this matter.

THIRD PARTY DETAILS (if applicable)

Name

Address

Post code

Date of birth DD/MM/YYYY

Relationship to claimant

Telephone