Cancellation Expenses
Claim Form

Dear Claimant,

Please complete this form in full and return to:

Mayday Travel Claims
13-16 Vine Street
Brighton
East Sussex
BN1 4AG

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)

	✓
Booking invoice from Travel Agent / Tour Operator / Airline	
Cancellation invoice from Travel Agent / Tour Operator / Airline	
Illness / Injury / Medical Report / Death Certificate (if applicable)	
Damage / burglary / flooding / fire or police report (if applicable)	
Completed & signed medical report (if the reason for the cancellation is for medical reasons)	
Insurance certificate details	
Other supporting documentation	

Claim reference number

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PERSONAL DETAILS

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other

Surname First name

Date of Birth DD/MM/YYYY N.I number

Address

Post code

Please tick your preferred method of contact

☐ Email ☐ Post

☐ Mobile ☐ Telephone

Telephone Mobile

Email Occupation

POLICY DETAILS

Insurance brand ☐ Single trip ☐ Annual multi trip

Policy number Date of issue DD/MM/YYYY

Date of outward travel DD/MM/YYYY Destination

Date trip booked DD/MM/YYYY Date of scheduled return DD/MM/YYYY

Travel agent Tour operator

CLAIM DETAILS

Reason for cancellation

Names of all persons cancelling under this insurance

Date the travel agent or tour operator was advised of cancellation

Verbally DD/MM/YYYY

In writing DD/MM/YYYY

If cancellation was due to a person not booked to travel, please state

Full name

Relationship

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CANCELLATION CHARGES AND PAYMENT INFORMATION

Total paid to travel agent / tour operator	£	Total amount you are claiming	£
Cancellation refund	£		

INFORMATION WE NEED FROM YOU FOR POSSIBLE RECOVERY OPPORTUNITIES

Your Travel Policy has conditions attached whereby you must provide us with any information that assists any recovery actions. This is a standard practice in the insurance market and contributions made from other insurance cover serves to keep the costs of your premiums down. The information provided should not affect your renewal premiums, or no claims discount.

Please answer the following questions and provide details as required. For questions that require a YES / NO response, please tick the appropriate boxes. Failure to do so may delay your claim.

1. Do you have a bank account? ☐ Yes ☐ No

A bank account you hold may offer Travel Insurance cover as part of the benefits. Under no circumstances will your bank account information be used other than to obtain a contribution from the Travel Insurance provider. This will not affect your bank account in any way.

Name of bank	(e.g.HSBC)	Type of account	(e.g.SILVER/GOLD)
Account holder name		Account number	

2. Was a credit card or debit card used to pay all or part of the trip cost? ☐ Yes ☐ No
(Certain credit or debit cards provide an element of travel cover)

Card issuer		Type of card	(e.g.VISA)
Card holder name		Card number	

3. Do you have a Household Contents insurance policy? ☐ Yes ☐ No
(Some household contents policies provide an element of travel cover)

Name of insurer		Policy name	
Policy number			

4. Do you hold any Private Medical Insurance? ☐ Yes ☐ No

Name of insurer		Policy name	
Policy number			

5. Do you consider anyone to blame for the incident? ☐ Yes ☐ No
If yes, please provide details.

It is a condition of the policy and your responsibility to provide sufficient documentation to support your loss. Failure to provide the required documentation, including the details of any other insurances, may delay and /or invalidate the claim.

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MEDICAL CERTIFICATE

If your trip has been cancelled due to illness or injury, this form should be completed by the usual medical practitioner of the ill / injured / deceased person (if applicable).

Please continue on a separate piece of paper if necessary. This information will be treated as PRIVATE AND CONFIDENTIAL. All other certificates are unacceptable. This form must be provided at the expense of the claimant. If a MEDICAL SELF DECLARATION was completed, please provide details.

1. Patient name	
2. Patient date of birth	DD/MM/YYYY
3. Please confirm the exact nature of the illness / injury or cause of death which makes cancellation of this trip medically necessary and / or prevents travel.	
6. Date on which you were first consulted re. 3 above. Were you aware of their proposed trip at this date?	DD/MM/YYYY
5. Has the Patient received a terminal prognosis?	
6. Has the patient suffered from the same or similar condition in the past? If Yes, is the present illness, in your opinion, related in any way to the past condition?	
7. a. Please give dates and details of any in-patient treatment: b. Date placed on waiting list. c. Nature of investigation or surgery d. Date of hospital admissions.	
8. If cancellation due to pregnancy please give: a. Date of confinement b. Date pregnancy confirmed c. Details of illness / injury connected with the pregnancy which gave rise to your recommendation not to travel	
9. a. Give details of any condition(s) which have been / are under supervision of a hospital /consultant / doctor or has required hospital admission or treatment in the previous 6 months. b. Give details if the Patient is / was suffering from any chronic disease, illness or from any physical defect or infirmity, including cancerous cardio-vascular, cerebro-vascular, renal, psychiatric or mental condition. c. Give details of any of the conditions advised in (a) and / or (b) which may have a bearing on the conditions(s) described in question 3. d. Give details if the Patient is / was awaiting result of any tests, investigations or if the person is on a waiting-list for any in or out-patient treatment or investigation. e. Give details of any continuous medication or changed medication or dosage increase, resulting in a deterioration in the condition in the previous 6 months.	
10. Date on which cancellation could have been anticipated.	DD/MM/YYYY
11. Date on which you advised the holiday should be cancelled.	DD/MM/YYYY
12. In your opinion, was cancellation medically necessary? If YES, was it solely due to the above condition? In your opinion when will the patient be fit for normal overseas travel?	
13. Please confirm that your patient was fit to travel at the time the insurance was issued.	
14. General remarks. (Please comment on the reason for not travelling if applicable).	

DOCTORS DECLARATION: I declare that I have examined the patient named above and / or have referred to their medical records and confirm that the information given above is a true and accurate statement, and further that no material information has been withheld.

GPNAME	SIGNED	DATE
GPSTAMP		

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IMPORTANT INFORMATION, PLEASE READ
ACCESS TO MEDICAL REPORTS ACT 1988

It may be necessary to apply for a medical report from a Doctor who has cared for you, and we ask that you give your consent by signing the claim form declaration. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988, and the procedures for dealing with the reports. You do not have to give your consent, but if you do, you can say whether you wish to see the report (or have a copy of it) before it is sent to us. If you say you wish to see the report, we must tell you at the same time as we write to the Doctor and we must tell him / her you wish to see the report. You have 21 days to contact the Doctor about arrangements for you to see the report.

Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied (if you ask). If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his / her costs.
Once you have seen a report, before it is sent to us, the Doctor cannot submit it until he has your written consent. You can write to the Doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your view on any part which he will not amend.

The Doctor is not obliged to let you see any part of a report if, in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctor's intentions towards you or if disclosure would be likely to reveal information about you, or the identity of another person who has supplied information about you, unless that person has consented to the information relates to, or has been supplied by, a health professional involvement in caring for you. In such cases, the Doctor must notify you in writing and you will be limited to seeing any remaining part of the report. If it is the whole of the report that is affected, he / she must not send it to us unless you give your written consent.

I HAVE BEEN INFORMED OF MY STATUTORY RIGHTS UNDER THE ACCESS TO MEDICAL REPORTS 1988 AS HIGHLIGHTED ON PAGE 5 AND CONSENT TO MAYDAY TRAVEL CLAIMS OBTAINING A FURTHER MEDICAL REPORT SHOULD IT BE NECESSARY. IN THAT EVENT I DO / DO NOT WISH TO SEE (OR HAVE A COPY) OF THE MEDICAL REPORT BEFORE IT IS SENT TO MAYDAY TRAVEL CLAIMS.

Claimant name	Claimant signature	Date DD/MM/YYYY

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PREVIOUS CLAIMS

Have you ever made any previous travel insurance claims? ☐ Yes ☐ No
If "Yes", please supply details below:

CLAIMANTS DECLARATION AND SIGNATURE

1. I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement.
2. To the best of my knowledge and belief I have not omitted any material information which would affect the insurers assessment of this claim.
3. I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that Mayday Travel Claims will not accept any liability if any payments are not distributed proportionately to the persons concerned.
4. I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to Mayday Travel Claims. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act 1988 (AMRA) or other similar legislation.
5. I am aware that an insurance claim made in the knowledge that any element thereof is fraudulent is a criminal offence and that this will invalidate the policy and will render me liable to prosecution.
6. I am, by this notice, aware that Mayday Travel Claims will retain a computerised record of this claim and that they may release certain information to other insurers or other interested parties. Mayday Claims maintain all data in accordance with the provisions of the Data Protection Act, 1984.

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