CLAIM FORM FOR CANCELLATION, CURTAILMENT OR REARRANGEMENT

Please note that we have to ensure that our claim form covers all types of claim. If you do not consider a question to be relevant to your circumstances please enter N/A next to the question

It is important that you make sure you carefully read the declaration at the end of the claim form and ensure that it is signed before returning the form to us. Failure to sign will result in your claim form being returned to you.

POLICYHOLDER'S DETAILS

Policy Number_____Start Date _____End date_____

Date insurance purchased_____

Mr / Mrs / Miss Forename_____Surname_____

Address_____

_____Post Code_____

Occupation_____ Date of Birth _____

Telephone Number_____ Email address_____

Date of Departure from Home_____ Anticipated/Scheduled Date of Return_____

Destination _____ Purpose of Trip_____

DETAILS OF YOUR HOLIDAY/JOURNEY

Date trip was booked/Arranged_____

Date Deposit was paid for trip _____ How much paid? £ _____

Date final balance was paid _____ How much paid? £ _____

If you did not return on the scheduled date, what date did you return? _____

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 _____

If not the policyholder:

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_____

_____

_____

_____

Please give details of any refunds in respect of your cancellation, curtailment or rearrangement from any third parties, e.g. airline or tour operator:

Name of Third Party	Amount Refunded	Date Refunded

If you have not received any refunds please provide evidence from the relevant third parties that no refund was due to you and attach to your claim form

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

Amount of Claim (Please clearly indicate Currency)	Reason for Claim	Office Use

(Please use additional sheet if necessary)

OTHER INSURANCE

Insurance companies have an agreement that if you hold two or more policies covering the same circumstances, each company will split the cost of the claim between them. It is a condition of your policy that you advise us if you have any other policies or have potential cover elsewhere. It is unlikely that you will lose any no claims bonuses attached to your other policies but if you have any concerns we suggest you contact the relevant insurer.

Do you have any other travel insurance cover (this could be included with your bank account or home insurance policy?) If YES please provide:

Name of Insurance Company: _____

Address _____

_____Policy Number _____

PAYMENT DETAILS

Should a payment become due under your insurance policy, your Insurers' preferred method of settlement is by BACS transfer and if this is convenient to you please complete the following:

Account name:		Account number:	
Bank name:		Sort Code:	

Alternatively:

Please advise to whom any settlement cheque due should be made payable_____

Please read the below carefully. No claim can be progressed unless the declaration has been signed.

Please note that your personal information may be used for the purposes of insurance administration and claims handling by us, AXA XL, its associated companies, its co-insurers, the insured and its broker and other third parties advising us or otherwise relevant to the handling of your claim. Your personal information may be used by AXA XL and its reinsurer(s) and reinsurance broker(s) for any reinsurance claim made by them, for renewal purposes and for their management reporting and for internal and external audit.

It may also be used for statistical purposes, for fraud and crime prevention and may be disclosed to Lloyd's or regulatory bodies in connection with compliance with any regulatory rules or codes.

Your personal information may be transferred to any country, including those outside the European Economic Area, for any of these purposes.

DECLARATION

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

Signature _____**Date**_____

Name (block capitals) _____

If your claim is due to death, illness or injury you must ensure that this form is completed by the usual GP of the person who has caused the claim and at your own expense.

MEDICAL REPORT

Name of Patient _____Patient's Date of Birth _____

Are you the patient's usual practitioner? YES/NO

How long have you acted in this capacity?: _____

Please advise the precise nature of the condition, illness or injury that has caused a claim to be made under this policy_____

What date did the patient first become aware of the illness/injury? _____

When was the patient first seen by any medical practitioner for this condition?_____

When were you first consulted about this condition (if different from above)?_____

Has the patient suffered from the same or a similar condition in the past? YES/NO

If 'Yes' please advise details and dates of all previous treatments _____

_____

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

If 'Yes' please advise the date they were put on the list_____

Did the patient consult you for permission to travel? YES/NO If YES please give date: _____

If so, did you consider the patient fit to travel at the time? YES/NO

If claim was due to pregnancy please give: Date pregnancy was confirmed_____

Expected due date_____

If the claim is in relation to the death of your patient please provide:

Cause of Death _____

Date of Death _____

Date of onset of illness/injury that caused the death _____

Was the patient considered terminal YES / NO If 'Yes' the date terminal diagnosis given _____

If 'No', the date it became apparent that the patient might not survive_____

Please provide any additional information you think may assist with the claim made:

_____

_____

Thank you for your time and assistance in this matter, please carefully read and sign the declaration overleaf.

DOCTOR'S DECLARATION

I have examined the patient and/or their 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 _____

Name _____

Qualification _____

Date _____

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

GUIDANCE NOTES

Please note that if you are unable to supply any of the evidence we request, you should include a separate covering note explaining this. This will enable us to deal with your claim promptly.

It is important that you provide evidence to support your claim and this should include but may not be limited to:-

- Original booking details and costs (this will need to be from the provider)
- Confirmation from providers of refunds provided or where none given confirmation of the same.
- Receipts for any additional costs incurred
- Any claim arising from death, illness or injury must have a completed medical report (pages 4 & 5)

Your claim form and supporting documents can be scanned and returned to us by email to Starpeak.Claims@csal.co.uk or by post to the following address:-

CSA Ltd/Gallagher Bassett
48 Felaw Street
Ipswich
Suffolk
IP2 8PN

Should you require any assistance in the completion of this form or any query regarding your claim please do not hesitate to contact us by telephone on +44 (0)1702 427190.