



Travel & Wintersports Insurance Claim Form for

HOLIDAY/TRIP CANCELLATION

Please complete this form send it with all supporting documents (documents may be sent on at a later date if necessary) to Mind The Gap Year, West House, West Street, Haslemere, Surrey, GU27 2AB. It will usually take about a week to 10 days for a claim to be processed.

Please note this must be done within 31 days of your accident or sickness. Late claims maybe declined.

The section below details the documents which you should enclose in order for us to deal with your claim. They must be **originals not photocopies** (other than for death). Please tick yes if enclosed and no if not.

- | | | | |
|---|---|---------------------------------|--------------------------------|
| a) MTGY Certificate Number | c) Holiday booking invoice or other documents issued as evidence of holiday/trip costs and dates. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| <div style="border: 1px solid black; height: 20px; width: 300px; margin-top: 5px;"></div> | | | |
| b) In cases of death, a photocopy of the death certificate. | d) If the claimant was a hospital in-patient, evidence to show admission and discharge dates. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |

Evidence of cancellation charges.

- | | | |
|---|---------------------------------|--------------------------------|
| e) Either: | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
| <p>For all inclusive tours (package holidays) organised by a Tour Operator please attach the Tour Operator's cancellation invoice showing cancellation charges levied and any refund made together with the tour operator's booking conditions.</p> <p>or</p> <p>For independently booked holidays or trips please attach the unused travel tickets (or vouchers) together with official confirmation of the cancellation charges levied and any refunds made from the Travel provider e.g. airline or coach.</p> | | |

NOTE

If the cancellation is due to medical reasons please ensure the medical certificate on this claim form is fully completed by the patients doctor. In the event of cancellation because of bereavement a copy of the death certificate will also be required.

SIGNATURE

Please sign and date the form on the final page.

TELECLAIMS

If you have no objection, in an effort to promote speedier and more customer-friendly claims handling we may find it easier to telephone you during the course of our normal working hours to discuss your claim and/or request further details. Please advise us of numbers on which you can be reached:

.....or.....

Failure to produce these documents above will delay the processing of your claim

PLEASE COMPLETE IN BLOCK CAPITALS

1. Claimant's title.....
 Forenames:
 Surname:

2. Address:

 Post Code:
 e-mail:

3. Telephone No. Daytime:
 Evening:

4. Occupation: Age:

5. The destination and country of this holiday/trip:

Office use

Office use

6. The period of your holiday/trip giving total number of days
 From: To:
 Total no. of days:

7. No. of people covered by the policy:

8. Name of tour operator from whose brochure you booked
 (if relevant):

9. Date holiday/trip booked:

11. a) Please advise the date on which you either decided or were advised to cancel:

b) Please advise the date on which you gave cancellation instructions either:
 i) Verbally (including telephone) ii) Written (including fax)

c) If the dates provided in 11(a) and 11(b) differ, please explain the reason:

12. Please describe the exact circumstances which have caused you to cancel the holiday. If the reason for cancellation is not of a medical nature please supply suitable documentary evidence to support the claim.

13.

	NAME	RELATIONSHIP	AGE
Please list all persons cancelling this trip who are insured by the policy and give their relationship to the person to whom the medical certificate applies, Include the name of the person whose illness/injury caused the cancellation if he/she was travelling with you.	1. ....	.....	.....
	2. ....	.....	.....
	3. ....	.....	.....
	4. ....	.....	.....
	5. ....	.....	.....
	6. ....	.....	.....

14. Was the person named on the medical certificate due to travel with you? YES NO

15. Should we require further medical information, it would help us to be able to contact the GP/attending specialist ourselves.
 Does the patient agree to this? Yes No
 Patient's name (printed)
 Signed (by patient)
 Dated

MEDICAL CERTIFICATE

This Medical Certificate is to be completed by the patient's usual GP or attending specialist.

Dear Medical Practitioner,

To avoid delay and unnecessary correspondence please complete this certificate answering each question as fully as possible.

Any fee for completing this certificate is the responsibility of the patient/claimant. Thank you

PLEASE COMPLETE IN BLOCK CAPITALS

16.	Name of person for whom these details apply:	
17.	How long have you been the Patient's GP?	
18.	Age and date of birth:	
19.	Relationship to claimant (if known):	
20.	When did the patient first consult you with regard to this condition and please give date and time of diagnosis? Date first consulted Date and time of diagnosis	
21.	(a) Please state exact nature of the illness/injury which made cancellation of the holiday/trip medically necessary and prevents travel:	
	(b) Has the patient received a terminal prognosis? Yes <input type="checkbox"/> No <input type="checkbox"/>	
	(c) Details of any previous medical history relevant to the above condition:	
	(d) Was the patient under any treatment or receiving medication (relevant to the above condition) Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details:	
	(e) Was the patient on a hospital waiting list for treatment for the condition which caused cancellation? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes, please provide details and dates:	
22.	If cancellation has occurred due to a pregnancy related condition please describe the condition and why the pregnancy necessitates cancellation: a) Date pregnancy confirmed: b) E.D.D.:	
23.	Were you aware of the holiday plans when you were first consulted? Yes <input type="checkbox"/> No <input type="checkbox"/>	
24.	Please confirm the date that cancellation could have been reasonably anticipated:	
25.	Was the patient due to travel on the cancelled trip? Yes <input type="checkbox"/> No <input type="checkbox"/> If yes a) Was the patient fit to travel on the date the policy was issued? Yes <input type="checkbox"/> No <input type="checkbox"/> Please refer to question 6a) before answering this. b) Was the patient travelling or had booked to travel contrary to medical advice? Yes <input type="checkbox"/> No <input type="checkbox"/> If no c) What was the patient's state of health on the date the insurance policy was issued? Please refer to question 6a) before answering this.	

I CERTIFY THAT THE REASON FOR CANCELLATION WAS DUE ONLY TO THE MEDICAL REASONS STATED ABOVE.

Name (print)

Signature

Qualifications

Date

Name and Practice Address (official stamp)

And Finally.....

To finalise your claim please sign the declaration below, however before doing so please read the following carefully:-

- Please study the policy wording and read the terms and conditions that relate to your claim.
- You are responsible for the cost of obtaining any documentation in support of your claim.
- This Insurance contains rights of subrogation and I confirm I assign to insurers all rights of recovery/salvage against any person or organisation and will do whatever necessary to secure such rights.
- Information on this form will be used by insurers to deal with any claim. Insurers may also pass this and any other information to other insurers and organisations involved in dealing with any claim. Insurers also share information to prevent fraud.

DECLARATION

I declare that, to the best of my knowledge and belief, all information stated herein is correct and that the insurance company is subrogated with all rights I may have against any third party(s).

I have not withheld any information from insurers within my knowledge connected with my claim.

I agree to provide further information or documentation that may be reasonably required.

Signature of Claimant: Date:

Warning

Making a fraudulent or knowingly exaggerated claim is a criminal offence and could render the offender liable to prosecution.

Copy

Please take a copy of this claim form and any attachments for your records and send the original with all supporting documents to Mind The Gap Year, West House, West Street, Haslemere, Surrey, GU27 2AB.