Insurance Administration Services Limited

Po Box 9, Mansfield, Nottinghamshire, NG19 7BL
telephone 0845 1300366 fax 01623 632861
email claims@ias-health.com

CANCELLATION/CURTAILMENT CLAIM FORM

IMPORTANT - PLEASE READ THE FOLLOWING CAREFULLY AND ENCLOSE THE DOCUMENTS REQUESTED WITH THIS FORM

Please ensure that you complete any blank sections on this form as failure to do so may delay the processing of your claim. When this form has been fully completed, signed and dated, it should be returned to the address shown above.
In order to avoid any delay in payment of your claim you should ensure that the following documents are enclosed :-

1. Your original Travel Agents premium receipt and/or insurance certificate/policy document as confirmation that you purchased insurance.
2. Your Tour Operators holiday invoice, cancellation invoice any other documentation requested in this form which relates to your claim.

The Insurance industry operates a number of anti-fraud initiatives which include TCEWS, operated by J S Management Ltd., and CUE, operated by Insurance Database Services Ltd. Details on these organisations can be provided on request.
Information given on this form may be stored electronically and shared with these organisations for this purpose. If you would prefer that the information given on this form is not used you should advise us.

THE DECLARATION ON THE REVERSE OF THIS PAGE MUST BE COMPLETED

YOUR TRAVEL CLAIM REFERENCE :
Always quote the above reference when contacting this office

PLEASE SECURELY ATTACH ALL SUPPORTING DOCUMENTATION TO THIS FORM

1. Insured (Full Name)					Mr/Mrs/Miss/Mast/Other
2. Occupation (of Insured)					
3. Full name of claimant (if different from above)					4. Date of Birth
5. Address (full including post code)					
	Email:				
6. Private Tel. No.				7. Business Tel. No.	
8. State the name of the person to whom payment should be made					
9. Name and Address of the Travel Agent/Tour Operator					
10. Is this an Annual Policy?	YES		NO		If YES please state the policy No.
11. Date of Booking				12. Policy issue date	
13. Departure date				14. Return date	
15. Country of holiday or journey destination					

YOUR TRAVEL CLAIM REFERENCE :

CANCELLATION OR CURTAILMENT

WHERE NECESSARY, PLEASE CONTINUE ON A SEPARATE SHEET OF PAPER

1. Date upon which cancellation/curtailment became necessary

2. Date advised to Travel Agent/Tour Operator

4. Please show below the Insured Persons who have cancelled. Please also indicate their relationship with the person for whom the medical certificate applies.

Name	Age	Relationship	Why cancellation/curtailment became necessary
a.			
b.			
c.			
d.			
e.			

5. If cancellation/curtailment is due to an injury, please advise exactly how the injury was sustained.

6. If cancellation/curtailment is due to involvement in a Road Traffic Accident, please advise:-

(a) Date of accident:

(b) Description of how accident occurred:

(c) Who, in your opinion, was responsible for the accident?

(d) Name and address of the Third Party:

(e) Details of your vehicle/other insurance: (i) Insurer (ii) Policy No.

(iii) Branch address

(f) Details of Third Party insurance (i) Insurer (ii) Policy No.

(iii) Branch address

(g) If solicitors have been appointed, please advise by whom and provide their name and address:-
Appointed by:
Name of Solicitors:
Address:

TO AVOID PAYMENT OF YOUR CLAIM BEING DELAYED PLEASE ENSURE THAT ALL DOCUMENTS REQUESTED ARE ENCLOSED AND ALL QUESTIONS HAVE BEEN ANSWERED

DECLARATION

I declare that these particulars are true and correct to the best of my knowledge.
I authorise the Insurers to approach my medical attendant for further information, should this be necessary.

Signature **Date**

YOUR TRAVEL CLAIM REFERENCE NO. :

IAS - Insurance Administration Services Limited
Po Box 9
Mansfield
Nottinghamshire
NG19 7BL

Dear Claimant

IMPORTANT

THE MEDICAL CERTIFICATE ON THE REVERSE OF THIS PAGE MUST BE COMPLETED BY THE MEDICAL ATTENDANT OF THE PERSON CONCERNED AND THEN RETURNED TO THE ADDRESS SHOWN ABOVE.

INFORMATION TO BE COMPLETED BY CLAIMANT :
Please state the DATE OF PURCHASE in the space* provided on the Medical Certificate on the reverse of this page.

Please state the REFERENCE NUMBER given to you if a Medical Self Declaration form was completed in relation to the person concerned, in the space* provided on the reverse of this page.

This information will assist the Medical Attendant in completing the Medical Certificate and help us to deal with your claim.

*This is given at the top right of the reverse of this form - please see box headed " MEDICAL CERTIFICATE ".

Thank you.
Claims Department

ACCESS TO MEDICAL REPORTS ACT 1998

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 you wish to see the report. You have 21days 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 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 Doctors intentions towards you or if disclosure would likely to reveal information about you or the identity of another person who has supplied information about you, unless that person has consented or the information relates to, or has been supplied by, a health professional involved 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 must not send it to us unless you give your written consent.

MEDICAL CERTIFICATE (Claimant Please See Over) DATE INSURANCE PURCHASED :

If your holiday/journey has been cancelled due to illness or iinjury, this form must be completed by the treating Medical Attendant (GP/Consultant/Specialist/etc.) of the person concerned. All other medical certificates are unacceptable. This form must be provided at the expense of the claimant.
If a MEDICAL SELF DECLARATION FORM was completed in relation to the person concerned, please state the screening number given, here: _____

1. Name of Patient

2. Age of Patient

3. How long have you attended the Patient?

4. Precise nature/diagnosis of the illness/injury or Cause of Death

5. Is the answer to Q. 4 pregnancy related? If YES, please complete the following before completing Q. 6

   a) What is the E.D.D.?

   b) Date pregnancy confirmed

   c) Why the pregnancy necessitates cancellation of the holiday/journey

6. Date of onset of illness/date of injury

7. Date upon which you were first consulted

8. Date referred to Specialist, Consultant, Hospital etc.

9. Date wait-listed for hospital/specialist in-patient or out-patient investigation or surgery

10. Nature of investigation or operation carried out/to be carried out

11. Date(s) of Hospital admission(s)

12. If a terminal prognosis
    a) Advise date ascertained

    b) Has the Patient been advised? If YES, when?

13. PREVIOUS MEDICAL HISTORY. WHERE 6 MONTHS IS STATED, THIS MEANS 6 MONTHS PRIOR TO THE DATE OF PURCHASE OF THE INSURANCE

   a) Give details of any condition(s) which has been/is 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 condition(s) described in Q. 4

   d) Give details if the Patient is/was awaiting results 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 from a deterioration in the condition in the previous 6 months

14. Was the booking made contrary to medical advice or for the purpose of obtaining medical treatment?

15. Date advised to cancel

16. Date of onset or deterioration of the condition which necessitated cancellation

17. If the Patient received in-patient treatment in the 6 months immediately preceeding the date of holiday/journey, did you approve the booking

18. Are you prepared to certify that solely due to the condition described in Q. 4 the claimant(s) is/are compelled to cancel or curtail the holiday/journey?

SIGNATURE :

PRINT NAME :

QUALIFICATIONS :

DATE COMPLETED :

ADDRESS & OFFICIAL STAMP OF PRACTICE/CLINIC/HOSPITAL :