



SINGLE/MULTITRIP TRAVEL

Cancellation / Loss of Deposit Claim Form

Once completed, please return your claim form to:

ONE Claims Ltd
1-4 Limes Court
Conduit Lane
Hoddesdon
Herts
EN11 8EP

Thank you for notifying us of your claim.

Please complete this claim form and return it to ONE Claims Ltd as soon as possible.

Please write clearly and in **BLOCK CAPITALS**.

Please provide full supporting documentation to avoid delays in processing your claim.

Claimant Details (The Insured Claimant(s)):

Title	Full Name(s)	Date of Birth	Occupation

Claimant address: _____

Postcode: _____ Email: _____

Telephone: _____ Fax: _____

Usual country of domicile: _____



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Certificate Number (Including Prefix): _____

Insurance Broker Name: _____

Address: _____

Travel Destination: _____ Country: _____

Resort: _____

Hotel: _____

Departure Date: ____/____/____

Return Date: ____/____/____

Purpose of trip: - (Delete as applicable)

Business / Pleasure

If Business: - (Delete as applicable)

Clerical / Manual

If Manual please provide details of nature of work: _____

If your Claim is agreed, how would you like to be paid?

Please tick box to choose preferred method of payment:

Cheque: Confirm Payee name: _____

Or direct to your bank account **(UK bank accounts only)**

Bank Name: _____ Branch: _____

Bank Sort Code: _____ Account No: _____

Account Holder: _____



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DOCUMENTS REQUIRED TO SUPPORT CLAIMS

IMPORTANT: ORIGINAL DOCUMENTS ARE REQUIRED.

WE CANNOT ACCEPT PHOTOCOPIES OR FAXED DOCUMENTS

Please Provide

1. The Tour Operators/Carriers Cancellation Invoice showing charges incurred.
2. Proof of cancellation, e.g.
 - a) Medical - The attached Medical Certificate to be completed.
 - b) Death - Death Certificate. Also the Medical Certificate is to be completed.
 - c) **Original Booking invoice.**

CANCELLATION/LOSS OF DEPOSIT

Reason for the Cancellation: _____

If cancellation has been caused by a person not travelling and not insured on your policy, please state relationship of that person to you: _____

Booking Date: _____ / _____ / _____	Date Cancelled: _____ / _____ / _____
Total Amount of Deposit Paid: _____	Date Paid: _____ / _____ / _____
Total Amount of Balance Paid: _____	Date Paid: _____ / _____ / _____
Amount Refunded: _____	Date Refunded: _____ / _____ / _____
Total Amount Claimed: _____	

If the reason for cancellation is medically related, the attached medical certificate **MUST** be completed by the usual Doctor for the person whose condition caused cancellation of the trip

DECLARATION - This must be signed.

I/We declare that the above statements are true and correct to the best of my/our knowledge and belief. I/we have not withheld any information within my/our knowledge connected with this claim. I/we agree to provide the insurer with any further information as may be reasonably required. I/we understand that the insurer does not admit liability by issue of this form. **WARNING - the making of a fraudulent or knowingly exaggerated claim is a criminal offence. We investigate all cases and any person suspected of fraud is reported to the police with whom we always co-operate.**

DATA PROTECTION ACT

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and may be shared with other organisations for this purpose. I/We understand that you may ask for information from other organisations to check the answers I/we have provided.

Signature(s) _____ Date _____ / _____ / _____



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MEDICAL CERTIFICATE

(TO BE COMPLETED BY THE GENERAL PRACTITIONER OF THE PERSON CAUSING THE CANCELLATION - ANY FEE DUE IS THE RESPONSIBILITY OF THE CLAIMANT)

PLEASE NOTE:- To avoid delay and unnecessary correspondence please ask the Doctor to complete this Certificate in BLOCK CAPITALS and to answer each question as fully as possible.

1)	Full name of the person to whom these medical details apply	
2)	Date of birth and Age	DoB: ___ / ___ / ___ Age: ___
3)	Are you his/her usual general practitioner? If not, in what capacity are you involved?	
4)	Please state the exact nature of illness/accident which made cancellation necessary.	
5)	Is there any previous medical history of the above condition or other relevant condition? If YES, please give dates and details	
6)	When did the patient first consult you with regard to this condition?	Date: ___ / ___ / ___
7)	When was the condition diagnosed?	Date: ___ / ___ / ___
8)	When was cancellation deemed necessary?	Date: ___ / ___ / ___
9)	Were you aware of the travel plans when first consulted?	
10)	If NO please confirm the first date on which cancellation could have been anticipated.	
11)	PREGNANCY ONLY (a) Date of LMP (b) Date pregnancy confirmed (c) Estimate date of confinement Exact medical condition within pregnancy	a) Date: ___ / ___ / ___ b) Date: ___ / ___ / ___ c) Date: ___ / ___ / ___
12)	At the time the trip was booked, please state whether:- (a) The condition was under control. (b) This was an exacerbation of an existing condition and if so the date of the exacerbation. (c) The patient was either on a waiting list for in-patient treatment or was actually an in-patient. (d) The patient had received a terminal prognosis. (e) If the patient was one of those travelling, the condition was a contra indication to do so. (f) Was travelling contrary to medical advice?	a) YES/NO ___ b) YES/NO ___ Date: _____ c) YES/NO ___ Date: _____ d) YES/NO ___ Date: _____ e) YES/NO ___ f) YES/NO ___

I certify that the cancellation was due solely to the medical reasons stated.

Name & Signature: _____

Qualifications: _____ Tel No.: _____

PRACTICE STAMP



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Your rights - Please read carefully

Access to Medical Records & Reports

Your consent is needed before we can apply for a medical report from your doctor, or other medical practitioner. This is governed by the Access to Medical Reports Act 1988 or the Access to Personal Files and Medical Reports (Northern Ireland) Order 1991 (made under the Northern Ireland Act 1974) and the Data Protection Act 1998.

In the event that you do not consent, we may be unable to process your claim, or continue with benefits for a claim already in existence. If you do consent then you have a choice whether or not to see the report before your doctor, or other medical practitioner, forwards it to us.

If you indicate below that you wish to see the report, you will have twenty-one (21) days after you have received our notification in which to contact your doctor, or other medical practitioner. If you indicate below that you do not wish to see the Report but later change your mind, you are entitled to request a copy directly from your doctor, or other medical practitioner, for up to six (6) months after it has been sent to us. If you are supplied with a copy of the Report your doctor, or other medical practitioner, is entitled to charge you a reasonable fee to cover costs. In addition, if your doctor, or other medical practitioner, spends time with you discussing your Report there is an additional entitlement to charge a fee to cover the time involved as this would not fall within the NHS Terms of Service.

Your doctor is not obliged to let you see any part of the report if it is felt that it would cause you harm, would indicate his intentions towards you or would reveal the identity or details of another person who is not a professional involved in your care. Your doctor, or other medical practitioner, will inform you if this applies to sections of your Report and you may see the remaining parts. If the whole Report is affected then it will not be forwarded to us without your further consent.

You are entitled to write to your doctor, or other medical practitioner, and request that your Report be amended if you consider it, or any part of it, to be incorrect or misleading. If your doctor, or other medical practitioner, is not prepared to amend your Report, a statement of your views can be attached to it.

Please tick the appropriate box, complete the form below (where applicable) and return it to us.

I wish to see the Report before it is sent.

I do not wish to see the Report before it is sent.

Please complete Your Details

Name: _____

Address: _____

Post Code: _____

Signed _____

Date of Signing ___ / ___ / _____

Please complete Medical Practitioners Details

Name: _____

Address: _____

Post Code: _____

Hospital Details

Name: _____

Address: _____

Post Code: _____

DATA PROTECTION ACT 1988

ONE Claims Ltd, will fairly and lawfully collect and record personal information that is supplied within and as a result of this form. We shall share information with your underwriters and their agents and, in certain cases, with other underwriters to help detect and prevent fraudulent claims. We require your consent to process information in this way and by completing and signing this form you are explicitly providing that consent.