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MORE TH>N is a trading style of Royal & Sun Alliance Insurance plc (No. 93792). Registered in England and Wales
Registered office: St Mark's Court, Chart Way, Horsham, West Sussex RH12 1XL. Authorised and regulated by the Financial Services Authority.

IMPORTANT

Please keep a separate note of this claim reference number and quote it whenever you contact us.

Date:

Dear

All personal information supplied by you will be treated in confidence by Royal & Sun Alliance Insurance Group of companies and will not be disclosed to any third parties except where your consent has been received or where permitted by law. In order to provide you with products and services this information will be held in the data systems of Royal & Sun Alliance Insurance Group of companies or our agents or subcontractors.

The Royal & Sun Alliance Insurance Group of companies may pass your personal information to other companies for processing on its behalf. Some of these companies may be based outside Europe in countries which may not have laws to protect your personal information, but in all cases the Group will ensure that it is kept securely and only used for the purposes for which you provided it. Details of the companies and countries involved can be provided to you on request.

HOLIDAY/TRIP CANCELLATION FORM

Thank you for requesting a claim form. Please ensure that you complete it fully and return to us

Please ensure you sign and date the form on the final page. Failure to do so will delay your claim.

Please check that we have correctly stated your name, initial(s), address and post code and amend if necessary.

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form. Thank you.

VERY IMPORTANT Please ensure you enclose the following **ORIGINAL** (not photocopied) documents (if not already sent).

- | | | | | | |
|--|---------------------------------|--------------------------------|--|---------------------------------|--------------------------------|
| a) Your MORE TH>N Travel Schedule (a photocopy is acceptable if you have annual insurance) | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> | b) The holiday booking invoice or other evidence of holiday/trip cost and dates. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
|--|---------------------------------|--------------------------------|--|---------------------------------|--------------------------------|

Evidence of cancellation charges.

- | | | |
|--|---------------------------------|--------------------------------|
| c) Either:
For all inclusive tours (package holidays) organised by a Tour Operator you must attach the Tour Operator's cancellation invoice showing cancellation charges levied and any refund made. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
|--|---------------------------------|--------------------------------|

or

- | | | |
|--|---------------------------------|--------------------------------|
| For independently booked holidays (or journeys) you must submit the unused travel tickets (or vouchers) together with official confirmation of the cancellation charges levied and any refunds made from the Airline/Ferry Company/Coach Company/ Hotel. | Yes
<input type="checkbox"/> | No
<input type="checkbox"/> |
|--|---------------------------------|--------------------------------|

CLAIM FORM NOTES RELATING TO MEDICAL CANCELLATION.

If the cancellation is due to medical reasons please ensure the medical certificate on this claim form is fully completed by the patient's doctor. Failure to have the medical certificate completed will delay the processing of your claim. In the event of cancellation because of bereavement a copy of the Death Certificate will also be required.

E-MAIL & TELECLAIMS

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

..... or

MEDICAL CERTIFICATE

The following medical certificate must 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

NOTE: PLEASE COMPLETE IN BLOCK CAPITALS

15.	Name of person for whom these details apply:		
16.	How long have you been the Patient's GP?		
17.	Age and date of birth of patient:		
18.	Relationship to claimant (if known):		
19.	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		
20.	(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"/> If YES, please confirm date.....
	(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:
21.	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.:		
22.	Were you aware of the holiday plans when you were first consulted?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
23.	Please confirm the date that cancellation could have been reasonably anticipated:		
24.	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? Please refer to question 6a) opposite before answering this.	Yes <input type="checkbox"/> No <input type="checkbox"/>
		b) Was the patient travelling 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) opposite 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)
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25. **Failure to provide this information could delay your claim**
 Certain household contents policies provide an element of travel cover. Do you have a household contents insurance policy or if you are living with your parents do they have a policy? Yes No
 If yes, please supply the name and address of the insurance company and policy number.
 Name:
 Branch Address:
 Policy No:

26. Do you have any other insurance which may cover this incident? (e.g.bank account etc) Yes No
 If yes, please supply details of the policy(ies) (If through your bank account, please provide the account number and the type of bank account you hold)

27. Was a credit card used to pay all or part of the holiday/trip cost? Yes No
 If yes, please supply the following information:
 Name of card: Cardholders name:
 Name of card issuer: Credit card no:
 (if different)

Please detail below the amount of the claim (excluding insurance premiums)

INDEPENDENT ARRANGEMENTS		
Travel Ticket Cost	£	Date Paid:
Amount Refunded	£	
NET CLAIM	£	
Accommodation cost/or other	£	Date paid:
Amount Refunded	£	
NET CLAIM	£	
Total amount Claimed	£	

PACKAGE TRIPS ONLY		
Deposit Paid	£	Date Paid:
Balance Paid	£	Date Paid:
Total	£	
Deduct Refund Received	£	
Total amount Claimed	£	

FOR OFFICE USE ONLY	FOR OFFICE USE ONLY	
TOTAL £	TOTAL X/S £	TOTAL NET £

IMPORTANT

PLEASE READ THE FOLLOWING CAREFULLY BEFORE SIGNING THE DECLARATION

Prior to returning the claim form please study the policy wording and read the terms and conditions as they relate to your claim. Please note, neither we nor insurers are responsible for the costs of obtaining documentation in support of the claim. We suggest you keep copies of all documentation for ease of reference.

THE INFORMATION ON THIS FORM WILL BE USED BY YOUR INSURERS TO DEAL WITH ANY CLAIM. YOUR INSURER MAY ALSO PASS NON PERSONAL INFORMATION TO OTHER INSURERS AND ORGANISATIONS INVOLVED IN DEALING WITH ANY CLAIM. INSURERS ALSO SHARE INFORMATION TO PREVENT FRAUD. SHOULD THE CLAIM BE INTENTIONALLY FALSE OR FRAUDULENT IN ANY RESPECT THEN ALL BENEFITS UNDER THE POLICY WILL BE LOST AND THE CLAIMANT WILL BE LIABLE FOR ANY COSTS INCURRED.

DECLARATION:

Please tick to confirm you have read and understood each line:

- I / We declare that the information contained within this claim form is true and correct to the best of my/our knowledge and belief. Yes
- I / We have not withheld any information or documentation from insurers within my/our knowledge connected with this claim. Yes
- I / We agree to provide further information or documentation as may be reasonably required. Yes
- I / We assign to insurers all rights of recovery / salvage against any person or organisation and will do whatever else is necessary to secure such rights. Yes

SIGNATURE OF CLAIMANT: **DATE:**