CURTAILMENT CLAIM FORM

Claim Number: A claim number will be allocated once this form is returned

Claims Settlement Agencies Limited
308-314 London Road, Hadleigh, Benfleet, Essex SS7 2DD
Tel: 0844 8262644 Fax: 0844 8262645
email: info@csal.co.uk www.csal.co.uk

Date:

Please use the above address for ALL correspondence & quote the above Claim Number in ALL subsequent communication.

When the Claim Form is received we aim to process it in five working days.

This claim form is being provided to you as requested in order that you can make a claim for Curtailment under the terms and conditions of your travel insurance policy.

Below is a Document Check List – please ensure you provide the correct documentation when submitting your claim as failure to do so may cause delays. We suggest you keep a copy of this claim form and other documents for your own records.

IMPORTANT DOCUMENT CHECK LIST Have you enclosed or previously provided the following **ORIGINAL** (not photocopy) documents?	✓ **PLEASE TICK**			
	Enclosed	**Previously Sent**	**Not Available**	**Not Applicable**
CERTIFICATE OF INSURANCE (or other proof of payment of insurance premium i.e. the Tour Operators booking invoice)				
HOLIDAY BOOKING INVOICE as issued by the booking Agent & Tour Operator				
For curtailment due to illness/injury abroad please submit **MEDICAL EVIDENCE** from the treating doctor abroad confirming the curtailment was medically necessary				
For Curtailment due to death, please submit the **DEATH CERTIFICATE** and arrange for the General Practitioner of the person concerned to complete the **MEDICAL CERTIFICATE** on page 3 of this claim form				
For Curtailment due to injury or illness of a relative in the UK, please arrange for the normal General Practitioner of the person concerned to complete the **MEDICAL CERTIFICATE** on page 3 of this claim form death				
For Curtailment due to non medical reasons, *please provide* ***DOCUMENTARY EVIDENCE of the necessity to return home early*** *(please check the terms and conditions of your policy for specific coverage details)*				
Details of and documents relating to original travel arrangements and any used/unused tickets				
Any other documentary evidence from which we can calculate your claim, which you feel is relevant.				

ACCESS TO MEDICAL REPORTS ACT 1988

If the claim is due to medical reasons you are responsible for arranging completion of the Medical Certificate on page 3 of the claim form. However, if on receipt of that Medical Certificate it is deemed necessary to obtain a further medical report from the doctor concerned in relation to this claim we will obtain further information from the doctor ourselves. In that event, before we can write to the doctor we require consent from the patient or next of kin as appropriate. Before signing the consent form, the patient concerned should read the following summary of their rights under the Access to Medical Reports Act 1988;

a) You can withhold your permission but if you do we will be unable to proceed with your claim if further information is required
b) If you wish to see the medical report, you must indicate on the claim form and contact your doctor within 21 days about arrangements to see the report. Whether or not you wish to see the report before it is sent to us, the doctor must let you see a copy for up to 6 months after it is supplied, if you ask
c) You can ask the doctor if he/she will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement you may append your comments

Your doctor can in certain circumstances withhold the report from you, or any part of it.

PLEASE ANSWER ALL QUESTIONS IN BLOCK CAPITALS – THANK YOU FOR YOUR CO-OPERATION

CLAIMANT DETAILS

Q01. Claimant's Details: Title: First Names: Surname:

Q02. Date of Birth: / / Present Age: **Q03.** Occupation:

Q04. Address:

Post Code:

Q05. Home Tel: Mob Tel: Work Tel:

E-mail:

Registered in England Number: 02558156 Registered Address: 72 New Cavendish Street, London, W1M 8AU

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HOLIDAY & INSURANCE DETAILS

Q06. Holiday booking date: / / Period from: / / to: / / Number of days:

Q07. Number of people in your party: **Q08.** Holiday Country & Destination:

Q09. Name of the travel agent who issued the policy:

Q10. Travel Insurance Policy Number (as shown on your insurance schedule):

Q11. Policy issue Date ***(very important)***: / /

Q12. Method of payment for the holiday (Delete as necessary): Credit Card / Debit Card / Cheque / Cash/ Other

If credit card was used please provide details: Card Issuing Company:

CLAIM DETAILS

Q13. Kindly list all persons curtailing the trip that are insured by this policy (list on additional sheet if necessary)

Insured Name	Age	Relationship to Patient (if applicable)
1.		
2.		
3.		
4.		

Q14. The date the holiday was curtailed: Date: / / **Q15.** Number of Nights Lost:

Q16. Please advise the reason for the curtailment of the trip - **please give details below and *provide the information as detailed in the DOCUMENT CHECK LIST on page 1 of this form*** Reason:

Q17. If the curtailment was due to a medical condition of a member of the travelling party have you also made a MEDICAL claim? **YES / NO**

Q18. Were the Assistance Company contacted **YES / NO** If 'YES' please provide name of company:

Assistance Company Ref No (if known): What type of assistance did they provide?

Refund of Holiday/Trip
Please note that Curtailment is calculated on a pro-rata basis

Total Cost of Holiday/Trip (excluding Insurance Premiums and Surcharges)	Number of Nights Lost	Amount Claimed
Final Pro-rata Amount Claimed		

Details Of Any Other Expenses Incurred
(continue on separate sheet if necessary)

Nature of Expense	Amount Claimed
Total Additional Expenses Claimed	

OTHER INSURANCE & PREVIOUS CLAIMS

Q19. Do you have any other insurance that covers the expenses you are claiming **YES / NO** If 'YES' please provide the full details of the policy holder (if different to claimant), the company name/address and policy number: Name of Policy Holder:

Company Name & Address: Policy Number:

Q20. Has this claim been submitted (or will it be) to the other insurer or to any other party? **YES / NO** Their ref (if known):

Q21. Have you or any other person named on this form ever made any previous claims on this type of insurance **YES / NO** If YES please give details (*please continue on a separate sheet if necessary):*

DATA PROTECTION NOTICE

Claims Settlement Agencies Ltd may use your information together with other information for underwriting, statistical analysis and claims. We may disclose your information to our service providers, agents and business partners for these purposes.

We may also share your information with other interested parties and outside agencies to check the details and prevent fraudulent claims. We may also disclose your information to our agents to investigate or prevent fraud.

CUSTOMER DECLARATION – To Be Completed By ALL Persons Claiming Aged Over 16

Claims Settlement Agencies Ltd, agents and business partners may contact anyone who can give them information relevant to my claim. I/ We confirm that the information that I/ we give is true and if any of the information given by me/ us (or anyone on my/ our behalf) is incorrect, I/ we agree that such inaccuracy may cause me/ us to forfeit my/ our rights under the policy.

In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.

Payments: Subject to admission of liability, we will make payment in favour of the claimant (aged over 16) as detailed in question **Q01** above but if an alternative payee is required please state below. I/ We have read and fully understood the above declaration.

Insured Name	Signature	Date of Birth	Date of Signature

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CONSENT TO OBTAIN A MEDICAL REPORT TO BE COMPLETED BY THE PATIENT OR NEXT OF KIN (AS APPROPRIATE)

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

Patient Name: Signed (Patient): Date: / /

Doctor's Name: Address:

MEDICAL CERTIFICATE

TO BE COMPLETED BY THE PATIENT'S GENERAL PRACTITIONER AT THE EXPENSE OF THE CLAIMANT

Note: The patient is the person whose medical condition has caused the curtailment of the holiday/trip and does not have to be a member of the travelling party. To avoid delays please complete this certificate in FULL and in BLOCK CAPITALS and answer each question as fully as possible. Thank you for your co-operation.

01. Name of the patient: Date of birth: / /

02. Relationship to claimant named in question Q01 on page 1 of the claim form (if not the claimant):

03. Please state the nature of the illness/injury that makes curtailment of the trip medically necessary:

04. When did the patient first consult you with regard to this condition and please give date and time of diagnosis

Date: / / Time: am/pm

05. Is there a previous history of the above condition or other relevant conditions? **YES / NO** If YES then please advise;

a. details: _____

b. date of onset: Date: ____ / ____ / _____ Diagnosis Date (if different): Date: ____ / ____ / _____

c. has the patient been under regular medical review for the condition(s) **YES / NO** If YES since when? Date: ____ / ____ / _____

d. is the patient on regular medication for the condition(s) **YES / NO** If YES date first prescribed: Date: ____ / ____ / _____

06. At the date the policy was effected (please refer to question **Q11.** overleaf for the date) or at any time during the 12 months prior to that date was the patient;

a. receiving in-patient treatment **YES / NO** If YES please give date: ____ / ____ / _____

b. on a waiting list for treatment **YES / NO** If YES please give date: ____ / ____ / _____

c. aware of a Terminal Prognosis **YES / NO** If YES please give date: ____ / ____ / _____

07. At the date the policy was effected (same date applies as per Q06 above) was the patient;

☐ Fit to travel ☐ Not Fit to travel ☐ Doubtful ☐ Not applicable as the Patient was not a member of the travelling party

08. If relevant to the condition has the patient suffered from any previously diagnosed psychiatric disorder **YES / NO**. If YES please give the cause of such condition:

09. What date did you advise the curtailment of the holiday necessary. Date: / /

10. If the curtailment is due to pregnancy please give;

a. Date of confinement: ____ / ____ / _____

b. Date pregnancy confirmed: ____ / ____ / _____

c. Date of LMP: ____ / ____ / _____

d. What illness/condition connected with the pregnancy gave rise to your recommendation to curtail?

11. Were you aware of the holiday plans when you were first consulted **YES/ NO** If NO please confirm the date curtailment could reasonably have been anticipated: / /

12. If the patient was not travelling, could the travelling person(s) have foreseen or anticipated any possibility that the medical condition or related condition could have caused the curtailment of the trip either;

a. At the date the holiday was booked (see and insert date from question **Q06** on page 2 for date) / / **YES / NO**

b. At the date the insurance was taken out (see and insert date from question **Q11** on page 2 for date) / / **YES / NO**

If unsure, please give further details:

13. Can you certify the sole reason for curtailment was due only to the condition stated in **Q03** above? **YES / NO**

Signature:

Qualifications:

Date: / /

Name & Address

Validation Stamp

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PAYEE'S BANK DETAILS				
IF WE APPROVE YOUR CLAIM, WE CAN CREDIT THE MONEY DIRECT TO YOUR BANK ACCOUNT. THIS METHOD IS QUICKER, SAFER AND MORE RELIABLE THAN PAYMENT BY CHEQUE. IF YOU WOULD LIKE US TO DO THIS, PLEASE COMPLETE THE FOLLOWING:				
Name of your Bank/Building Society:				
Bank Sort Code:				
Account Number:				
Name of Account Holder(s):				