Heritage Insurance Company

A member of the LIBERTY Group

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# CLAIM FORM FOR TRAVEL INSURANCE

## I. PERSONAL PROPERTY/MONEY AND DOCUMENTS CLAIMS SECTION

CLAIM REFERENCE:
Please complete this form and return it with relevant documentation to the address below.
Please do not hesitate to call if you have any queries

### A. PERSONAL DETAIL

FULL NAME (AS PER POLICY) :
Date of Birth
Occupation:
Telephone
Hrs of Contact

### B. INSURANCE DETAILS

Policy Name
Date Trip Originally Booked
Travel Dates : From : To:
Name of Travel Agent, If any Name of Tour Operator if any.
Hotel Accomodation details Resort Country

(INCLUDING BAGGAGE DELAY)

Date of Loss/Damage:
Place of Loss/Damage:
Full Details/Circumstances
Was the Loss /Damage Reported to the Police?:
Date of Loss /Damage Reported to the Airline?
If NO, please state reason
Date of Loss /Damage Reported to the Tour Operator?
If NO, please state reason
Is your property also covered under a Household Contents Insurance?
☐ Yes ☐ No If YES, please give details below:

### C. PERSONAL PROPERTY, MONEY AND DOCUMENTS

| *FULL Details of Items Lost/Damaged* | *Date of Purchase* | *Shop and Town where purchased* | *Purchase Price* | *Amount Claimed* | *Evidence of Value* | *For Office USE ONLY* |
|---|---|---|---|---|---|---|
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Please continue on a separate sheet if there is insufficient space. Please mark all documents with your claims reference

State to whom settlement should be paid:
State prefered currency if not US$:

### THE FOLLOWING ORIGINAL DOCUMENTS MUST BE SENT WITH YOUR CLAIM FORM FOR CLAIM PROCESSING

Indicate whether enclosed

1. Your original holiday/flight confirmation and/or receipt or deposit receipt ☐ Yes ☐ No
2. Your certificate of Insurance ☐ Yes ☐ No
3. Your travel tickets ☐ Yes ☐ No
4. Police, Airline or Tour Operator report ☐ Yes ☐ No
5. Evidence of Ownership such as original receipts, valuations, credit card receipts ☐ Yes ☐ No
6. Any other relevant documentation to support your claim ☐ Yes ☐ No

## II. CURTAILMENT/MISSED DEPARTURE TRAVEL DELAY/PERSONAL LIABILITY CLAIMS SECTION

CLAIM REFERENCE:
Please complete this form and return it with relevant documentation to the address address at end of this form.
Please do not hesitate to call if you have any queries.

### CANCELLATION/LOSS OF DEPOSIT/CURTAILMENT

Reason for Cancellation or Curtailment

### (1) FOR CANCELLATION/LOSS OF DEPOSIT

Date Trip originally booked
Total Cost of holiday
Date Insurance purchased
Amount Refunded
Date Trip Cancelled
Amount Claimed

### (1) FOR CURTAILMENT OF TRIP

Date Trip originally booked
Date of Incident causing Curtailment
Date Insurance purchased
Actual Return Date
Original Transport Method(Air/Ferry/Coach....)
Amounts claimed for Additional Expenses:

IF THE REASON FOR THE CLAIMS IS MEDICAL, THE ATTACHED MEDICAL CERTIFICATE OVERLEAF MUST BE COMPLETE BY THE USUAL DOCTOR OF THE PERSON WHOSE CONDITION GIVES RISE TO THE CLAIM

### D. MISSED DEPARTURE/TRAVEL DELAY

Reason for Delay or Missed Departure

### (1) For Missed Departure

Point of Departure
Date & Time of Planned Departure
Transport Used (Air/Coach/Ferry, etc.)
Method Employed to Rejoin Trip
Amount Claimed

## (2) For Travel Delay

Scheduled Date and Time of Departure:

Actual Date and Time of Departure

Number of hours delay

Flight/Ferry number

Airline/Ferry Company

## E. PERSONAL LIABILITY

Address of holiday apartment/hotel

Date and Time of Incident:

Full Details of Incident (continue on a separate sheet if necessary)

### THE FOLLOWING ORIGINAL DOCUMENTS MUST BE SENT WITH YOUR CLAIM FORM FOR CLAIM PROCESSING

Indicate whether enclosed :

1. Your original holiday/flight confirmation and/or receipt or deposit receipt ☐ Yes ☐ No
2. Your certificate of Insurance ☐ Yes ☐ No
3. Your travel tickets ☐ Yes ☐ No
4. Proof of cancellation, medical certificate redundancy notice, court summons, etc ☐ Yes ☐ No
5. Receipts for additional travel and/or accommodations expenses (if applicable) ☐ Yes ☐ No
6. Confirmation of cause of claim from carrier, breakdown organization or garage, etc ☐ Yes ☐ No
7. Confirmation from the carrier stating reason for delay includingactual travel time ☐ Yes ☐ No
8. Any other relevant documentation to support your claim ☐ Yes ☐ No

## (iii) MEDICAL EXPENSES CLAIM SECTION

CLAIM REFERENCE:

Please complete this form and return it with all relevant documentation to the above address. Please do not hesitate to call if you have any queries

## F. MEDICAL AND EMERGENCY EXPENSES/HOSPITAL BENEFIT

Date of Injury/Onset of Illness

Place of Injury/Illness

Details of Injury/Illness

Circumstances of Accident (if applicable)

Have you suffered from the same/similar condition before? ☐ Yes ☐ No

If YES, please ask your usual doctor to complete the attached medical certificate.

PLEASE NOTE: Any charge made by a doctor for medical reports must be paid by the claimant

If hospitalized, please state :

Admission Date : Discharge Date :

Were you in possession of a valid E111* form? ☐ Yes ☐ No

*(*For travelers in the E.C. only)*

If NO, please provide your National Insurance Number :

Please sign to give SAS authority to use your E111.

Name :_____ Signature _____

| *Date of Treatment* | *Expenses Claimed* | *Amount Claimed* | *For Office USE ONLY* |
|---|---|---|---|
| | | | |
| | | | |
| | | Total Amount Claimed | |

Please continue on a separate sheet if there is insufficient space. Please mark all douments with your claims reference

## State to whom the settlement should be paid

### THE FOLLOWING DOCUMENTS MUST BE SENT WITH YOUR CLAIM FORM FOR CLAIM PROCESSING

Indicate whether enclosed :

1. Your original holiday/flight confirmation and/or receipt or deposit receipt ☐ Yes ☐ No
2. Your certificate of Insurance ☐ Yes ☐ No
3. Hospital, Doctor, Chemist, Dentist receipts for amounts claimed(Non-UK only) ☐ Yes ☐ No
4. Receipts for additional travel and/or accomodation expenses(if applicable) ☐ Yes ☐ No
5. Confirmation of In-patient treatment for hospital benefit claim ☐ Yes ☐ No
6. Any other relevant documentation to support your claim ☐ Yes ☐ No
7. Confirmation of In-patient treatment for hospital benefit claim ☐ Yes ☐ No
8. Confirmation from the carrier stating reason for delay includingactual travel time ☐ Yes ☐ No

## DECLARATION

I declare that to the best of my knowledge all particulars contained in this form are true and correct.

Signed: _____ Date: _____

The completed form shoul be retuned to above address ( Refer Page 1 )

### MEDICAL CERTIFICATE

CLAIM REFERENCE: THIS CERTIFICATE TO BE COMPLETED BY THE USUAL DOCTOR OF THE PERSON WHOSE CONDITION GIVES RISE TO THE CLAIM. ANY CHARGE MADE FOR COMPLETION OF THIS DOUMENTATION IS THE RESPONSIBILITY OF THE INSURED PERSON AND IS NOT REFUNDABLE BY THE INSURERS

### CLAIMANT'S DETAILS

Name : Date of Birth

### NAME OF PATIENT IF DIFFERENT FROM CLAIMANT

Patients D.O.B . Relationship to Claimant

### PATIENT'S CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

I authorise the medical practitioner named below to release any information required by the Insurers or their appointed agents to enable my claim to be processed.

Signed: _____ Date: _____

### MEDICAL CERTIFICATE

### CLAIM REFERENCE

Dear Doctor,

The above named Insured Person has submitted a claimed on their travel Insurance Policy. In order for us to process this claim, we would be grateful if you would respond to the questions below:

How long have you been the patient's usual doctor?

Precise nature of medical condition/illness/injury/cause of death

Date first consulted for this problem

Was the patient waitlisted for a hospital admision?. ☐ Yes ☐ No

Please advise dates of waitlist and admission as appropriate

Please advise details of any relevant previous medical history, including any chronic and/or recurring medical problem of a serious nature which has necessitated consultation, medication or in-patient treatment over the last 30 months:

In your opinion, was the patient fit to travel as proposed ? ☐ Yes ☐ No

Had the patient been given a terminal prognosis? ☐ Yes ☐ No

Is the patient pregnant? ☐ Yes ☐ No

If YES, please give E.D.D

I,Dr:

Confirm that the above information is correct.

Signed : _____

Qualifications :

Date : _____ Official Stamp.

Address :

The completed form shoul be retuned to above address ( Refer Page 1 )