This form is to be fully completed and returned immediately to your Broker or Cox Claims Management Ltd

Failure to answer all questions may prejudice your claim.

Cox Claims Management Ltd

Cardigan House, Castle Court, Phoenix Way, Swansea, SA7 9LA

Claims Assistance – Tel: 0870 606 0096 Facsimile: 01792 762799

MEDICAL & ADDITIONAL EXPENSES, HOSPITAL BENEFIT, CANCELLATION & CURTAILMENT CLAIM FORM

IMPORTANT: THE FOLLOWING DOCUMENTS ARE REQUIRED TO SUPPORT **ALL** CLAIMS. Please also read notes overleaf regarding specific claims. (Please send **ORIGINAL** documents as photocopies and faxes are not acceptable).

a) Certificate of Insurance including endorsements if any.
b) Tour operators booking invoice showing cost inc. insurance premium.
c) Tour operators receipt showing total paid.
d) Airline, Ferry, Coach tickets unless returned for refund.
e) Travel itinerary.
f) Proof Insurance premium paid if not issued through the tour operator.

1. CERTIFICATE

Number____

Policyholder's Name____

____

2. CLAIMANT

Name____

Occupation____

Date of Birth____

Address____

____

__________________________________Post Code______________

Daytime Phone____

Country of Residence____

Relationship to Policyholder___________________________________

3. TRAVEL DETAILS

Travel/Tour Operator____

Travel Destination____

Departure Date____

Return Date Intended__________________ Actual________________

Date Insurance Purchased______________________________________

4. MEDICAL EXPENSES

Date/Time & Place of accident or onset of illness____________________

____

Details of illness or injuries sustained_____________________________

____

____

____

If accident, please give circumstances______________________________

____

____

____

If illness, please give details of any previous history__________________

____

____

____

Please provide **ORIGINAL** receipts/invoices for treatment received.

Did you contact the Emergency Services Company? YES/NO

If not why not?____

____

5. FORM E111

Please provide form E111 if not presented whilst abroad or National Insurance No. (European travel only).

Was form E111 utilised? YES/NO

How?____

____

National Insurance Number_____________________________________

6. ADDITIONAL EXPENSES INCURRED

Period of extended accommodation from __________________________

to __________________________

What were the original return travel arrangements?___________________

____

____

Please provide medical evidence of the necessity to extend your stay and **ORIGINAL** receipts and travel tickets for additional travel and accommodation

Did you incur any additional expenses in returning home? YES/NO

If YES, please give details at 10 overleaf.

7. HOSPITAL BENEFIT

Hospital name and address______________________________________

____

Date/Time admitted____

Date/Time discharged____

Please provide written confirmation from the treating hospital of the date and time of admission and discharge. The usual Doctor in the UK must complete the medical certificate on the claim form following hospitalisation abroad.

8. CURTAILMENT

Was it necessary to curtail your trip? YES/NO

If YES, please give reason______________________________________

____

Did you contact the Emergency 24 hour Service? YES/NO

Date returned____

If accompanied, by whom_______________________________________

Please enclose written confirmation from the treating Doctor abroad that it was medically necessary for you to curtail your trip. If a trip is curtailed as the result of an illness/death which occurred in the UK the medical certificate on the claim form must be completed by the usual Doctor in the UK.

9. CANCELLATION/LOSS OF DEPOSIT

Reason for cancellation____

____

____

Name of person whose illness, injury etc caused cancellation and relationship to Insured____

____

Booking date______________________ Date cancelled_____________

Total Deposit paid £________________ Date paid________________

Total balance paid £________________ Date paid________________

Amount refunded £__________________ Date refunded_____________

Total claimed £____________________

Please supply tour operators cancellation invoice detailing costs incurred and any refund obtained together with the following evidence: -

Injury/Illness:: Medical cert. on this claim form to be completed by usual GP of person giving rise to claims.

Death: ORIGINAL or certified copy of Death Certificate.

Redundancy: Confirmation from employer of the date on which Claimant was first notified of redundancy together with length of service.

Jury Service: Letter from court or court subpoena.

10. EXPENSES CLAIMED

List expenses claimed and treatment received (Please supply original receipts)	Currency & Amount	Receipt attached	To whom should payment be made?

THIS MEDICAL CERTIFICATE NEED ONLY BE COMPLETED FOR CLAIMS IN RESPECT OF CANCELLATION AND CURTAILMENT OR WHERE THE INSURED PERSON HAS SOUGHT OUTPATIENT OR INPATIENT MEDICAL TREATMENT WHILST ABROAD

MEDICAL CERTIFICATE: To be completed by the regular medical attendant of the person whose injury/illness gives rise to the claim.
NB. This Certificate is to be completed at the Claimant's own expense and is not recoverable from Insurers

Full name of patient________________________ Age/Date of Birth________________________

Are you the usual medical attendant? YES/NO If YES, for how long?________________________

If NO, what is your involvement in this matter?________________________

____

State the precise nature of medical condition/illness/injury/cause of death________________________

____

If accidental injury please state how this was caused________________________

____

Exact date of onset________________________ Date first consulted________________________

Date when deterioration occurred or terminal diagnosis made________________________

Was patient waiting for admission to hospital? YES/NO If YES, please give date they were placed on the waiting list__________

If already admitted to hospital, please give date________________________

Please give details of any previous medical history that has a bearing on the condition stated above________________________

____

In your opinion, at the time of booking, was the patient fit to travel? YES/NO

At the time of booking was the patient undergoing medical treatment? YES/NO If YES, what treatment was being given and was it reasonable for the patient to continue with their travel plans?________________________

____

In your opinion, at the time the balance of holiday cost became due, was the patient fit to travel? YES/NO

At the time the balance of holiday cost became due was the patient undergoing medical treatment? YES/NO If YES, what treatment was being given and was it reasonable for the patient to continue with their travel plans?________________________

____

State of the patient's health at the time the insurance was taken out________________________

If the cancellation is due to pregnancy please give the expected date of delivery and the reason for cancellation advice________________________

____

Exact date when you advised the patient to cancel their trip________________________

Are you prepared to confirm that the Claimant had to cancel their travel arrangements solely as a result of the condition stated above? YES/NO

Official Surgery Stamp

I certify that the information given above is correct

Doctors signature________________________

Doctors name (please print)________________________

Qualifications________________________

Date________________________

Some of the information which you give us about this claim may be passed to the other insurance companies you tell us about. They will give us information about your policy with them, and we may ask them to pay a contribution to this claim. A contribution payment is normal practice where two or more policies cover the same thing. If another company contributes to your claim with us, it should not affect any no claim discounts you may have with them.

DECLARATION: To be signed by all claimants

I/We declare all the information supplied is true and correct in every aspect and that no relevant information has been withheld. I/We understand that some of the information provided may be made available to other Insurers for Underwriting and Claims Handling purposes. I/We consent to the seeking of information from other Insurers to check the answers I/we have provided and I/we authorise the giving of such information.

On settlement, I/we transfer all rights of subrogation, salvage and recovery to the Insurer and/or their Claims Handlers.

Signature________________ Date__________ Signature________________ Date__________

Name (please print)________________________ Name (please print)________________________

Signature________________ Date__________ Signature________________ Date__________

Name (please print)________________________ Name (please print)________________________