Office G:18
Bromley Old Town Hall
30 Tweedy Road
Bromley
BR1 3FE
Tel: 02083150732
Email: **adjusters.uk@vanameyde.com**

Dear Sir/ Madam

**Travel claim form**

To ensure that our claims team can efficiently handle your claim, please ensure all relevant questions relating to your claim are completed

To assist in the handing of your claim you should:

- Please ensure all supporting documentation is provided, including the full policy schedule
- Please ensure that all relevant questions are answered, and that all appropriate sections, boxes and signatures are completed, failure to do so may delay the processing of your claim.
- Any questions or queries please telephone us on **0208 315 0732**

Please return the complete claim form and documentation to **adjusters.uk@vanameyde.com** or alternatively you can send to:

Van Ameyde UK
Office G:18
Bromley Old Town Hall
30 Tweedy Road
Bromley
BR1 3FE

Kind Regards

Van Ameyde UK Limited

# Travel Claim Form

**Section A – To be complete by all claimants**

Policy Number:

Policy Start Date: DD/ MM /YYYY

Policy End Date: DD/ MM /YYYY

Date Insurance Purchased: DD/ MM /YYYY

Departure Date: DD/ MM /YYYY

Return Date: DD/ MM /YYYY

Country of Destination:

Travel/ Tour Operator:

Purpose of trip (please select one): Business ☐ Leisure ☐

Claimant 1 Title and Full Name:

Occupation: Date of Birth: DD/ MM /YYYY

Claimant 2 Title and Full Name:

Occupation: Date of Birth: DD/ MM /YYYY

Claimant 3 Title and Full Name:

Occupation: Date of Birth: DD/ MM /YYYY

Claimant 4 Title and Full Name:

Occupation: Date of Birth: DD/ MM /YYYY

Claimant 5 Title and Full Name:

Occupation: Date of Birth: DD/ MM /YYYY

Address:

Post Code: Contact Number:

If providing a mobile contact please tick this box ☐ if you **do not** wish to receive SMS updates on your claim

Email:

Please complete the correct section relevant to your claim:

**Section B – Travel Delay/ Missed Departure**

Reason for Delayed/ Missed Departure:

**Travel Delay**

Schedule Date& Time of Departure: DD/ MM /YYYY H H:MM Flight/ Ferry/ Train No:

Schedule Date& Time of Departure: DD/ MM /YYYY H H:MM Flight/ Ferry/ Train No:

No of Hours Delayed: Company name:

**Missed Departue**

Point of Depature of Trip:

Point of Connection Failure:

Method of Transport:

Means employed to rejoin holiday/ trip:

Amount Claimed: £

**Section C – Cancellation/ Loss of Depoist**

Reason for Cancellation:

If cancellation has been caused by a peron not travelling and not insured on your poicy, please state realtion of that person to you:

Booking Date: DD/ MM /YYYY Date Cancelled: DD/ MM /YYYY

Total amount of Depoist Paid: £ Date Paid: DD/ MM /YYYY

Total Amount of Balance Paid: £ Date Paid: DD/ MM /YYYY

Amount Refunded: £ Date Refunded: DD/ MM /YYYY

Total amount Claimed: £

If the reason for cancelation is medically realted, the medical certifictae on page **MUST** be compltetd by the usual Doctor for the person whose condition caused the cancellation of the trip

*****Please ensure that the G.P. when completing the nedical certifictae on page , is aware of the date that the insurance policy was purscahsed on page 2*****

**Section D – Medical expenses & Curtailment**

Date of Illnes/ Injury: DD/ MM /YYYY Time oF Ilnness/ Injury: HH: MM

Location of Illness/ Injury:

Details of any previous history of illness or Injury:

If Injury, please state circumstances:

Did you take an EHIC?: Yes / No If Yes was it presented: Yes / No

Did you contact the emergency service as on the policy: Yes / No

If you hold any private medical insurance please confirm the following:

Scheme Name:

Policy Number:

Period of extended accommodation (if applicable) From: DD/ MM /YYYY To: DD/ MM /YYYY

What were you original return travel agreements:

Were any additional expenses incurred in returning home: Yes / No

If Yes enter reasons and cost below in STATEMENT OF CLAIM.

If Hospitalised, Date/ time admitted: DD/ MM /YYYY H H:MM Date/ time discharged: DD/ MM /YYYY H H:MM

In case of early return though illness, berevaement or injury please completethe following:

Date on which you returned: DD/ MM /YYYY Were you accompanied? Yes / No

If Yes, by whom:

Reason for the curtailment:

Were additional expenses incurred? Yes / No

**PLEASE ENCLOSE WRITTEN CONFIRMATION FROM THE DOCTOR ABROAD THAT IT WAS MEDICALLY NECESSARY FOR YOU TO CURIAL YOUR HOLIDAY**

**STATEMENT OF CLAIM**

| Please List Expenses being claimed and the treatment received | Currency paid and amount claimed | Receipt Attached | State to whom payment should be made |
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**Total Claimed £**

# MEDICAL CERTIFICATE

**To be completed in BLOCK CAPITALS by the General Practitioner of the person whose illness/injury give cause for the claim.** Any charge made for the completion is the responsibility of the insured and is not refundable under the Insurance Policy.
PLEASE ANSWER ALL QUESTIONS. TICKS. DASHES, N/A ETC. **WILL NOT BE ACCEPTABLE.**

| | |
|---|---|
| 1 Full Name of Patient/Person whose condition has caused the claim | |
| 2 Date of birth | |
| 3 Are you the regular medical attendant?<br>a) if so how long?<br>b) If not, what is your involvement with this matter? | YES/NO<br>a)<br>b) |
| 4 Please state precise nature of:<br>Medical condition/illness/injury/cause of death that causes the claim<br>If injury, state how this was caused | |
| 5 a) Please state exact date of onset as in 4<br>b) Date first consulted<br>c) Date first diagnosed<br>d) Date when there was any serious deterioration, if applicable | a)<br>b)<br>c)<br>d) |
| 6a) Please state, with dates, any incidents relating to the condition as in 4, during the 2 years prior to the date the insurance was effected, to include medication and treatment, tests, specialist referrals or hospitalisation.<br>If no history, state NONE | |
| 6b) Please confirm whether your patient is suffering from or has reviously suffered from any of the following conditions:<br>Heart Related Condition, Hypertension, Diabetes, Arterial Disease Kidney Disease, Malignant Diseases (Cancer), Lung and /or Respiratory Disease (including Asthma) or had a Stroke<br>If yes, please provide dates of incidents, to include medication and treatment, tests, specialist referrals or hospitalisation.<br>Continue on a separate sheet if insufficient room | YES/NO |
| 7 Has the person named in 1 above received a terminal prognosis.<br>If yes: on what date was this given to<br>a) the person named in 1 above<br>b) the claimant, if not the same person | YES/NO<br><br>a)<br>b) |
| 8 Has the patient ever had a psychiatric or psychological disorder?<br>If yes: state:<br>a) date of diagnosis<br>b) treatment received<br>c) dates of in-patient admission/s | YES/NO<br><br>a)<br>b)<br>c) |
| 9 Was the patient waitlisted for hospital admission?<br>If yes: state:<br>a) date waitlisted<br>b) date admitted<br>c) for what condition/procedure | YES/NO<br><br>a)<br>b)<br>c) |
| 10 Please state:<br>a) Whether the patient consulted you prior to their journey as to the advisability of undertaking the holiday or journey.<br>If so, on what date<br>b) Whether, in your opinion the patient was fit to travel at the time of departure | YES/NO<br><br>Date<br><br>YES/NO |
| 11 Please provide details of state of patient's health at the time the Insurance was purchased | |
| 12 If claim is a result if pregnancy, please advise:<br>a) Date pregnancy confirmed<br>b) Expected confinement date<br>c) Exact reason for the cancellation | <br><br>a)<br>b)<br>c) |
| 13 Please advise the date when it first became apparent that the holiday should be cancelled. | |
| 14 Please state the exact date you advised the need to cancel | |
| 15 Are you prepared to certify that, solely due to the condition described in 4 above, the claimants are compelled to cancel the travel | |

**TO BE COMPLETED BY THE GENERAL PRACTITIONER -** I certify that the information given is complete and correct.Name ease

Name (Please print ).....

Address ..... ..

Qualifications .....

Signed .....Date .....

DOCTORS OFFICIAL STAMP

**Section E – Personal effects/ Money**

Date of Loss/ Damage/ Delay: DD/ MM /YYYY Place:

Full details of circumstances:

Was loss/damage reported to the courier? YES / NO
Was loss/damage reported to the airline? YES / NO
Was loss reported to the police? YES / NO
If NO, please state reason why:

Please state the total value of all baggage and personal effects carried on your trip: £

Are the items solely your property? YES / NO

If NO, please specify

Name, Address and Policy Number of household contents Insurers of the address where you reside.
Refer to note below, Household Insurers.

Policy Number: Insurers Name:

Insurers Address :

Is there any other relevant policy that may cover your belongings? e.g. Barclaycard, Amex.. YES / NO

If YES, please give details:

Have you ever made an insurance claim for personal property or money? YES/NO
If YES, please give precise details:

Has a claim been submitted to any other insurer and/or authority in respect of this loss: YES / NO
If YES, please give details:

**EVIDENCE OF OWNERSHIP/VALUE**
Insurers require claims to be supported by evidence of ownership and original purchase price. Please forward original purchase receipts, guarantee cards, instruction manuals, credit card slips/statements or original insurance valuations to confirm ownership of the items being claimed. Replacement estimate/receipts do not prove ownership and are therefore not acceptable.

**HOUSEHOLD INSURERS**
Insurers contribute to the settlement of each other's claims. This shares costs and helps to keep premiums down. Please give full details of your household contents policy where requested. A contribution made to us should not affect any no claim bonus under your policy.

| Full description of the articles lost or damaged and the extent of damage where applicable. In respect of delay baggage claims, please list the additional costs incurred | Shop/Store and location where purchased | Date/year of Purchase | Evidence of value *Tick where applicable* | Initial of owner | Original price paid | Amount claimed in sterling | OFFICE USE ONLY |
|---|---|---|---|---|---|---|---|
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| | | | | | Total | **£** | |

**Section F – Personal Liability**

Address of Holiday residence/ hotel:

Date and Time of Incident: DD/ MM /YYYY H H:MM

Place of Incident:

Have You admitted Liability? Yes / No

If YES, please explain why:

Full Details of Circumstances:

**Please note any correspondence received from any third party is to be forwarded to us unanswered**

**Section G – Payment Details**

In the event that your claim is accepted and any payments are due to be made please select how you wish for the payment to be made

Direct transfer to your account: ☐

Cheque made payable to you: ☐

If direct transfer selected please confirm the following details:
Name and address of bank:

Account holders name:

IBAN Number:

Sort Code:

Account Number:

**Section H – General Data Protection Regulation (GDPR)**

By signing this claim form you consent to Van Ameyde using The information you supply, or that we collect, about you may be used by us and our agents for the purposes of claims administration, fraud investigation, management information, staff training and / or debt administration and recovery.
And to process sensitive personal data about you where this is necessary (for example health information or criminal convictions). This may mean we have to give some details to third parties involved in providing insurance cover. These may include insurance carriers, third-party claims adjusters, fraud detection and prevention services, reinsurance companies and insurance regulatory authorities.

Where such sensitive personal information relates to anyone other than you, you must obtain the explicit consent of the person to whom the information relates both to the disclosure of such information to us and its use by us as set out above. You have certain rights with regard to your personal data processed by us. We will ask you to provide evidence of your identity before we can take instructions to fulfil your rights.

**Right of access** - You have the right to access your personal data that we hold on our database about you and this can be done by making a Subject Access Request to our Data Protection Officer.

**Right of rectification** - If you believe the data we hold about you is incorrect, you have the right to have this corrected.

**Right to erasure** - With exceptions, you have the right to request the deletion of personal data we hold about you. We will consider every request for erasure on its merits.

**Right to restrict processing** - You have the right to request us to restrict the processing of your personal data held on our database for the period it takes us to rectify any inaccurate data about you. This right can also be used to prevent us from deleting your data at the end of the retention period in the unlikely event that you need it to establish, exercise or defend a legal claim.

**Section I – Declaration**
TO BE COMPLETED BY ALL CLAIMANTS

I/We declare that all the information supplied is true and correct in every aspect and that no relevant information has been withheld. On settlement, I/We transfer all rights of subrogation, salvage and recovery to the Insurer and/or their Loss Adjuster.

Signed: Date: DD/ MM /YYYY

Signed: Date: DD/ MM /YYYY

Signed: Date: DD/ MM /YYYY

Signed: Date: DD/ MM /YYYY

Signed: Date: DD/ MM /YYYY

Please use the following area to add any additional details that could assist with handling your claim: