



International Travel Protection

Claim Form Cancellation Expenses

Here is your Claim Form, as requested. Please complete it fully and return it to us.

Please ensure that you quote the Claim Number shown opposite on all correspondence.

CLAIM NO.

Personal details (required for all claims)

Surname _____

Forename(s) _____

Title _____ National Insurance No. _____

Date of Birth _____

Telephone No. Day _____

Evening _____

Home address _____

_____ Postcode _____

E-mail _____

Policy details (required for all claims)

Policy number

Date of booking

Name of Travel Agent

Company name
(if applicable)

Date of travel

Name of Tour Operator

Date of issue

Date of return

Destination

Claim details

Reason for cancellation _____

Names of all persons cancelling _____

Date travel agent or tour operator advised of cancellation

Verbally _____

In writing _____

If cancellation was due to a person not booked to travel please

state name and relationship _____

Cancellation charges and payment information

Total paid to agent/operator

£

Cancellation charges applied

£

Payment method

(Credit Card/Cheque/Cash)

Refund given

£

Total amount claimed

£

Please provide us with details of ANY credit cards which YOU hold e.g. Visa Gold Card from Barclaycard

ETI – International Travel Protection Claims Service

14th Floor, Leon House
201-241 High Street
Croydon CR9 1ER, England
Tel: +44 (0) 870 2415039
Fax: +44 (0) 870 2415038
E-mail claims@travel-insurance.com

The Financial Ombudsman Service

South Quay Plaza 2
183 Marsh Wall
London E14 9SR
www.financial-ombudsman.org.uk

The Association of British Insurers

51 Gresham Street
London, EC2V 7HQ
www.abi.org.uk

ETI was licensed by DTI (Department of Trade and Industry) in 1994 to conduct general insurance business in the UK and is now supervised by The Danish Insurance Supervisory Authorities – www.finanstilsynet.dk

ETI is a Branch of Europæiske Rejseforsikring A/S, a company incorporated in Denmark – www.europaeske.dk

ETI is registered in England, Reg. Branch No. BR002862 and Company No. FC018451.
www.travel-insurance.com

Medical Certificate

To be completed by the usual medical practitioner of the ill/injured person (if applicable). Please continue on a separate piece of paper if necessary. This information will be treated as PRIVATE AND CONFIDENTIAL

1. Patient Name	2. Patient Age	
3. Please confirm the exact nature of the illness/injury which makes cancellation of this trip medically necessary and prevents travel.		
4. Date on which you were first consulted re. 3 above. Were you aware of their proposed trip at this date?		
5. Has the Patient received a terminal prognosis?		<input type="checkbox"/> Yes <input type="checkbox"/> No
6. Has the patient suffered from the same or similar condition in the past? If YES, is the present illness, in your opinion, resulted in any way to the past condition?		
7. a) Please give dates and details of any in-patient treatment. b) Date placed on waiting list.		
8. If cancellation due to pregnancy please give a) Date of confinement b) Date pregnancy confirmed c) Details of illness/injury connected with the pregnancy which gave rise to your recommendation not to travel.		
9. Date on which cancellation could have been anticipated.		
10. Date on which you advised the holiday should be cancelled		
11. In your opinion, was cancellation medically necessary? If YES, was it solely due to the above condition? In your opinion when will the patient be fit for normal overseas travel?		
12. Please confirm that you patient was fit to travel at the time the insurance was issued.		
13. General remarks. (Please comment on the reason for not travelling if applicable).		
<p>DOCTORS DECLARATION: I declare that I have examined the patient named above and/or have referred to their medical records and confirm that the information given above is a true and accurate statement, and further that no material information has been withheld.</p>		
Signature _____		<div style="border: 1px solid black; width: 100%; height: 100%; display: flex; align-items: center; justify-content: center;"> <p><i>This section to be validated by surgery's stamp</i></p> </div>
Print name _____		
Date signed _____		

Claimants declaration and signature

- I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement.
- To the best of my knowledge and belief I have not omitted any material information which would affect the insurers assessment of this claim.
- I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that 'ETI' will not accept any liability if any payments are not distributed proportionately to the persons concerned.
- I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to 'ETI'. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act (AMRA) or other similar legislation.
- I am aware that an insurance claim made in the knowledge that any element thereof is fraudulent is a criminal offence and that this will invalidate the policy and will render me liable to prosecution.
- I am, by this notice, aware that 'ETI' will retain a computerised record of this claim and that they may release certain information to other insurers or other interested parties ETI maintain all data in accordance with the provisions of the Data Protection Act, 1984.

DATA PROTECTION ACT

The insurance industry operates a number of anti fraud initiatives. The information given on this form may be stored electronically and shared with other organisations for this purpose. If you would prefer the information given here not to be used in this way, you should tick this box.

I have read and understand the declarations above

Claimant(s) full name(s)	Claimant(s) signature(s)	Date
	X	
Full name of an authorised representative of the corporate policy holder (corporate and/or educational group cover)	Signature of authorised representative	Date
	X	