Cancellation Expenses
Claim Form

Please complete this claim fully and return to us by following the postal instruction below.

Please return your completed form to:

Staysure Trip Cancellation Claims
PO Box 9
Mansfield
Nottinghamshire
NG19 7BL

Cancellation Expenses
Claim Form

Personal details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other

Family name First name

Date of birth D D M M Y Y Y Y N.I number

Address

Post Code

Daytime tel no. Evening tel no.

Email address Occupation

Policy details

Company name if applicable

Policy number Date of issue D D M M Y Y Y Y

Destination Date of booking D D M M Y Y Y Y

Date of travel D D M M Y Y Y Y Date of return D D M M Y Y Y Y

Travel Agent Tour operator

Claim details

Reason for cancellation

Cancellation Expenses
Claim Form

Names of all persons cancelling

Date travel agent or tour operator advised of cancellation

Verbally D D M M Y Y Y Y

In writing D D M M Y Y Y Y

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

Full name

Relationship

Cancellation charges and payment information

Total paid to travel agent/ tour operator £

Payment method

Cancellation charges applied £

Refund given £

Total amount claimed £

Information we need from you for possible recovery opportunities

Your Travel Policy has conditions attached whereby you must provide us with any information that assist any recovery actions. This is a standard practice in the insurance market and contributions made from other insurance cover serve to keep the cost of your premium down. The information provided should not affect your renewal premium or no claims discount.

Cancellation Expenses
Claim Form

Please answer the following questions and provide details as required. For questions that require a **Yes / No** response, please tick the appropriate boxes. Failure to do so may delay your claim

1. Do you have a bank account? Yes ☐ No ☐

A bank account you hold may offer travel insurance cover as part of the benefits. Under no circumstances will your bank account information used other than to obtain a contribution from the travel insurance provider. This will not affect your bank account in any way.

Name of bank (e.g. HSBC)	Type of account	Account holder name	Account number

2. Was a credit card or debit card used to pay all or part of this trip costs? Yes ☐ No ☐

Certain credit or debit cards provide an element of travel cover.

Card issuer	Type of card (e.g. Visa)	Cardholder name	Card number

3. Do you have a Household Contents insurance policy? Yes ☐ No ☐

Some Household content policies provide an element of travel cover.

Name of insurer	Policyholder name	Policy number

4. Do you hold any Private Medical Insurance? Yes ☐ No ☐

Name of insurer	Policyholder name	Policy number

5. Do you consider anyone to blame for the incident?	Yes ☐	No ☐

If yes, please provide details

It is a condition of the policy and your responsibility to provide sufficient documentation to support your loss. Failure to provide the required documentation, including the details of any other insurances, will delay and may invalidate your claim.

Access to Medical Reports 1988

It may be necessary to apply for a medical report from a Doctor who has cared for you, and we ask that you give your consent by signing the claim form declaration. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988, and the procedures for dealing with the reports. You do not have to give your consent, but if you do, you can say whether you want to see the report (or have copy of it) before it is sent to us. If you say you wish to see the report, we must tell you at the same time as we write to the Doctor and we must tell him/ her you wish to see the report. You have 21 days to contact the Doctor about arrangements for you to see the report.

Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied (if you ask). If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his / her costs.

Once you have seen a report, before it is sent to us, the Doctor cannot submit it until he / she has your written consent. You can write to the Doctor asking him / her to amend any part of the report which you consider incorrect or misleading and have attached to the report a statement of your view on any part which he / she will not amend.

The Doctor is not obliged to let you see any part of a report if, in his / her opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctors intentions towards you if disclosure would likely to reveal information about you or the identity of another person who has supplied information about you, unless that person has consented to the information relates to, or has been supplied by a health professional involvement in caring for you. In such cases, the Doctor must notify you in writing and you will be limited to seeing any remaining part of the report. If it is the whole of the report that is affected, he / she must not send it to us unless you give your written consent,

Cancellation Expenses
Claim Form

Medical Certificate

If your holiday / Journey has been cancelled due to illness or injury this form must be completed by the usual medical practitioner of the ill/injured/deceased person (if applicable)

Please continue on a separate piece of paper if necessary. This information will be treated as PRIVATE AND CONFIDENTIAL. All other certificates are unacceptable. This form must be provided at the expense of the claimant. If a MEDICAL SELF-DECLARATION was completed, please provide details.

1. Patient name	
2. Patient age / date of birth	
3. Please confirm the exact nature of the illness/ injury or cause of death which makes cancellation of this trip necessary and / or 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? If so please provide date prognosis was given	
6. Has the patient suffered from the same or similar condition in the past? If YES, is the present illness, in your opinion, related in any way to the past condition?	
7. a) please give dates and details of any inpatient treatment b) Date placed on a waiting list. c) Nature of the investigation surgery d) Date of hospital admission	
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 recommendations not to travel	

(Please continue on next page.)

Cancellation Expenses
Claim Form

9. a) Give dates of any condition(s) which have been / are under supervision of a hospital/ Consultant/ Doctor or has required hospital admission or treatment in the previous 6 months b) Give details if the Patient is / was suffering from any chronic disease, illness or from any physical defect or infirmity, including cancerous, cardio-vascular, cerebro-vascular, renal, psychiatric or mental condition c) Give details of any of the conditions advised in (a) or (b) which may have a bearing on the condition(s) described in question 3. d) Give details if the patient is / was awaiting results of any tests, investigations or if the person is on a waiting list for any in or out patient treatment or investigation e) Give details of any continuous medication or changed medication or dosage increase resulting in a deterioration in the condition in the previous 6 months.	
10. Date on which the cancellation could have been anticipated	
11. Date on which you advised the holiday should be cancelled	
12. 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?	
13. Please confirm that your patient was fit to travel at the time the insurance was issued.	
14. General remarks (Please comment on the reasons for not travelling if applicable).	
Doctors Declaration: I declare that I have examined the patient named above and / or 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.	This section to be validated by surgery's stamp

Print Name:	Signed:	Date:

Cancellation Expenses
Claim Form

Settlement Details:

Claims payments made by BACS transfer or other electronic banking system can be made and credited to your account more quickly than a cheque.

By entering your bank account details, you confirm that ERV has full authority to remit monies directly to that account by the BACS or other electronic banking system. You also accept that, providing payment remitted to the bank account designated by you, ERV shall have not further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.

Name of account holder:
Type of current account, e.g. Platinum/Gold/Premier:
Name and address of Bank/Building Society:
Sort Code:
Account number:
If you require payment by cheque, to whom should the settlement be made? *Please note if the bank details provided are illegible or we are unable to validate, payment will be made by cheque payable to the claimant and posted to the address provided.*

Claimant(s) Declaration and signature

1. I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement
2. To the best of my knowledge and belief, I have not omitted any material information which would affect the insurers assessment of the claim
3. 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 'Staysure Claims' will not accept any liability if any payments are not distributed proportionately to the persons concerned
4. I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to 'Staysure Claims'. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act 1988(AMRA) or other similar legislation.
5. I am aware that in insurance claim made in the knowledge that any element thereof is fraudulent is a criminal offence and that this will invalidate the policy and result in the claim being rejected. It will also render me liable to prosecution
6. I am, by this notice, aware that 'Staysure Claims' will retain a computerised record of this claim and that they may release certain information to other insurers or other interested parties. Staysure maintains all data in accordance with the provisions of the Data Protection Act, 1984.

Cancellation Expenses
Claim Form

Data Protection Act

Personal Information – means information that identifies and relates to you or other individuals (i.e. your dependants). By providing **Personal Information** to ERV Insurance Services you give us permission for its use as described below. Full details about our use of **Personal Information** can be requested by writing to us at info@ervinssvs.co.uk

When providing **Personal Information** about another individual to us, you confirm that you are authorised to provide it for use as described below.

Types of Personal Information we may collect and why:

Depending on our relationship with you, **Personal Information** collected may include:

- identification and contact information,
- payment card and bank account,
- credit reference and scoring information,
- sensitive information about health or medical condition,
- and other **Personal Information** provided by you.

Personal Information may be used for the following purposes:

- Insurance administration, (communications, claims processing and payment)
- Decision-making on provision of insurance cover and payment plan eligibility,
- Assistance and advice on medical and travel matters,
- Management and audit of our business operations,
- Prevention, detection and investigation of crime, (fraud and money laundering)
- Establishment and defence of our legal rights,
- Legal and regulatory compliance, including compliance with laws outside your country of residence,
- Monitoring and recording of telephone calls for quality, training and security purposes.

Sharing of Personal Information:

Personal Information may be shared with our group companies, Brokers and other distribution parties, Insurers and Reinsurers, Credit Reference Agencies, healthcare professionals and other service providers. **Personal Information** may be shared with other third parties (including government authorities) if required by law. **Personal information** (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

Security and retention of Personal Information:
Appropriate legal and security measures are used to protect **Personal Information**. All third party service providers are also selected carefully and required to use appropriate protective measures. **Personal Information** will be retained for the period necessary to fulfil the purposes described above.

International transfer:
Due to the nature of our business, **Personal Information** may be transferred to parties located in other countries with different data protection laws than in your country of residence.

Data requests:
To request access or correct inaccurate **Personal Information**, or to request the deletion or suppression of **Personal Information**, or object to its use, please e-mail: info@ervinssvs.co.uk; PO Box 9, Mansfield, Nottinghamshire NG19 7BL

Cancellation Expenses
Claim Form

DECLARATION I declare that the whole of the statements made and any other supplementary statements forming part of this claim are true in every respect and understand that a false declaration may invalidate my claim and could result in prosecution. I give permission for my **Personal Information** to be used and shared in the ways described above. I confirm that I will not provide any **Personal Information** about another person without that person's permission.

I have read and understand that the declaration above and provided the necessary documentation to substantiate my claim

Claimant(s) full name(s)

Claimants signatures

Date D D M M Y Y Y Y

Full name of authorised representative of the corporate policy holder (corporate and / or education group cover)

Signature of authorised representative

Date D D M M Y Y Y Y

I / We authorise _____ to act on my behalf in this matter.

Claimants signatures

Date D D M M Y Y Y Y