HOLIDAY AND TRAVEL CLAIM FORM

INSURANCE CORPORATION

Read carefully

Please fully complete sections 1. 2. & 3 along with the relevant sections to your claim. Please also sign the claim on the back of this page and enclose all necessary documentation.

PLEASE COMPLETE IN BLOCK CAPITALS

E-mail: icci.claims@insurancecorporation.com

P.O. Box 160
St. Peter Port,
Guernsey, GY1 4EY
Channel Islands
Telephone: 01481 713322
Facsimile: 01481 714426

P.O. Box 742
St. Helier,
Jersey, JE4 8ZZ
Channel Islands
Telephone: 01534 700200
Facsimile: 01534 768447

www.insurancecorporation.com

Policy No. _____ Broker/Agent _____

Section 1 - Insured/Claimants Details

Mr,Mrs,Ms,Miss

Full Name _____ _____

Full Address _____

_____ Postcode

Telephone No. (Home) _____ Telephone No. (Business) _____

Date of Birth _____

Occupation _____

Number of persons involved _____

Section 2 - Insurance Details

Was this a business trip? Yes ☐ No ☐

Is there any other insurance in force (e.g. Householders/Personal Accident/all risks/travel etc) which also covers this loss/expense?
If **'YES'** State details

Insurance company _____

Address _____

_____ Postcode

Policy/coupon No. _____

Have you or any other insured person ever before sustained a loss of this nature?
If **'YES'** state details

Date _____ Amount _____

Circumstances _____

Insurance Co. involved _____

Section 3 - Travel Booking Details

Date booked _____ Countries visited _____

Departure date _____ Tour operator _____

Return date _____ Holiday/Travel reference No. _____

Did the claim arise whilst taking part in winter sports? Yes ☐ No ☐

Section 4 - Loss of deposits and tour charges

Please state the reason for the cancellation or curtailment of Holiday/Travel.

If due to illness or injury please ask your GP to fill in the medical certificate attached

Date of the event leading to the cancellation or curtailment

If due to illness, has the insured suffered from this before? Yes ☐ No ☐
If **'YES'** State details

Amount claimed
Please attach invoices

Amount of deposits	Less refund	Net amount claimed
£	£	£

Section 5 - Delayed departure

Scheduled departure time hrs

Actual departure time hrs

Overall delay time hrs

Reason for delay

Please enclose a note of proof from your carrier

Section 6 - Personal Accident

Date and time of accident

Place of accident

Please state the cause of the accident and the nature of the injuries

Please attach medical certificates

Name of doctor

Address

Postcode

Please state the period during which you have been totally disabled as the sole and direct result of the accident

Are you still totally disabled? Yes ☐ No ☐

If **'NO'** from what date were you able to attend to some part of your business?

Section 7 - Medical, repatriation and other out of pocket expenses

Nature and cause of illness or injury

Date of illness or injury giving rise to expense

Amount claimed in respect of (net of money obtained from Social Insurance)

a) Medical and similar expenses £

b) Additional out of pocket/repatriation expenses £

Please attach medical certificates and invoices

Section 8 - Loss or damage to Personal Baggage

Date and time of accident | Place of accident

Please give full particulars of circumstances giving rise to the loss or damage
(Please retain damaged articles and indicate an address at which they may be inspected)

Please state the total value of baggage accompanying person(s) making a claim (including cash, cheques, travel tickets)

£

If the loss or damage occurred whilst the baggage was in transit or otherwise in the custody or control of others, have any steps been taken to claim against these persons? Yes ☐ No ☐

Please identify them and attach any correspondence

If claim is in respect of articles lost or stolen, has a thorough search been made and notification sent to shipowners, hotel proprietors, Police or other parties who may be able to assist in their recovery? Yes ☐ No ☐

Please give details with the Police report number

If lost/stolen/damaged at an airport please include the property irregularity form

Description of baggage	Replacement cost	Date purchased	Value before loss/damage allowing for wear and tear	Net amount claimed, allowing for salvage value
	£		£	£
	£		£	£
	£		£	£
	£		£	£
	£		£	£

Please ensure to attach all the relevant information and documentation relating to your claim

I/We declare that the statements made are true to the best of my/our knowledge and belief and I/we claim the amount above in respect of the items mentioned.

Fair Obtaining Notice:
Insurers and their agents share information with each other to prevent fraudulent claims and to assess whether to offer insurance including the terms, via the Claims and Underwriting Exchange register, operated by Insurance Database Services Ltd. A list of participants is available on request. The information you supply on this form, together with the information you have supplied on your application form and other information relating to the claim, will be provided to participants.

Signature of Insured | Date / /

IF THE SPACE ON THIS FORM IS INSUFFICIENT, PLEASE CONTINUE ON A SEPARATE SHEET

Medical certificate to be completed by doctor

Information will be treated as confidential

Name of person to whom details apply	
Address	
Age	
Please confirm the exact nature of the illness or injury preventing travel	
What date were you first consulted for the problem?	
Please give details of treatment	
Has the patient suffered from the same or similar condition in the past?	
If yes, has the present illness resulted from the past condition?	
In your opinion is cancellation medically necessary?	
On what date could cancellation have been anticipated?	
On what date did you actually advise that the holiday should be cancelled?	
Do you consider that the patient was fit to travel at the time the holiday was booked?	
When do you consider that the patient will be fit to travel?	

I have examined the patient and I declare that the medical information given is correct to the best of my knowledge.

Name _____ Qualifications _____

Business Address _____

_____ Postcode

Telephone No. _____

Signature of Insured _____ Date / /