Travel Insurance

Boots Travel Claims
PO Box 60108
London
SW20 8US

Tel: 0845 125 3820
Fax: 0870 130 1950

Dear Sir / Madam,

So that we may process your claim as quickly as possible please ensure that you fully complete and sign all the relevant sections and return it to us with the following **ORIGINAL** documentation: (Please note that should you require your original documents returned, you must request this in writing within 90 days of submitting your claim. Only electronic copies of your documents will be stored after this time).

For all claims:

- Flight or travel documents showing your booking dates, departure dates and return dates and amount paid to enable us to validate your trip and policy entitlements.
- Accommodation and excursion booking invoices showing your booking dates, departure dates and return dates and amount paid to enable us to validate your trip and policy entitlements.
- Cancellation invoices for each portion of your trip / holiday. For example flights, accommodation and excursions. These cancellation invoices should show the portion of the trip / holiday cancelled or not used and detailing the amount you have been charged for cancelling or confirming no refund has been provided. Your trip booking agent / travel agent may be in a position to provide you with these cancellation invoices for insurance purposes.

If you are cancelling on medical grounds, including death:

- The attached medical certificate completed by the registered General Practitioner/Practice of the person whose medical condition has given rise to this claim. Please note the cost of completing this document is not covered by your insurance.
- A certified copy of the death certificate. Please note the death certificate will be returned to you without the need to request it.
- If the deceased was an insured person, we will require a copy, only, of the grant of probate/letters of administration issued in respect of the deceased's estate.

If you are cancelling as a result of a 3rd party incident:

- Details of the circumstances which caused the accident.
- If a third party was involved please provide the name and address of the third party and their Insurance details if known.
- In the event that you are pursuing a claim for damages against a third party please provide the name and address of any appointed solicitor and their reference number.

If you are cancelling as a result of redundancy:

- A statement from your employer confirming the following:-
  - The date that you were first made aware of the pending redundancy.
  - Whether you were employed on a PAYE basis.
  - Whether this was a qualifying redundancy within the terms of the Employment Protection Act.

If cancellation is for a reason other than those detailed in the points above please forward independent written evidence of the incident or circumstances that have resulted in the submission of your claim.

Chartis Europe Limited changed its company name to AIG Europe Limited on 3 December 2012. This change of name does not impact your insurance cover or your ability to claim.

When we receive your claim submission, we will assess it and correspond with you further in due course.

Yours sincerely,

Travel Claims Department

CLAIM DECLARATION

RETURN POST: Travel Claims Department
PO Box 60108, London, SW20 8US

Date Sent: **Claim Ref:**

Please answer all the questions contained in this claim form, leaving items blank, using ticks, dashes and N/A may make it necessary for us to return your claim forms or lead to us asking unnecessary questions thus delaying the processing of your claim.

Personal details - required for all claims

Mr/Mrs/Miss/Ms		Home address			
Surname					
Forenames					
Date of birth					
Occupation		Postcode		Mob. No	
National ins. No.		Home tel.		Work tel	
Nationality		Email			

Please CIRCLE your preferred method of contact: **EMAIL / WORK TEL / HOME TEL / MOBILE / POST**

Policy details

Policy number			
Date issued			
Policy start date		Policy end date	
Date the loss occurred		Number of insured travellers	

Please advise the section(s) of the policy you are making the claim under:

Total amount claiming

Travel details

Travel booking reference			
Travel agent / Tour operator			
Date of booking holiday		No. in party	
Depart date		Return date	
Total days			
Destination country			
Destination city			

How we use your information

Information which you supply to us, including sensitive information relating to health or a medical condition, may be used in a number of ways, for example:

- to assess and process your claim
- to prevent crime (including fraud and money laundering)
- for audit, record keeping, statistical analysis and optional customer satisfaction surveys
- to comply with any legal requirement on us or other companies in our group
- to make decisions about you and other people when selling insurance

We may share information with our contractors (including service providers), agents and other international group companies for these purposes. Information may be put on a register of claims and shared with other companies, including insurers, for fraud prevention. We will share information with other third parties if required to do so by law.

We may transfer your information outside of the European Economic Area ("EEA") for the above purposes, including for secure electronic storage. Whenever we transfer or share information outside, or inside, the EEA we ensure that it is protected.

If you give information to us about another person, you will obtain that person's permission beforehand to provide the information and for us to use it as described above.

You can obtain further information by writing to our Data Protection Officer by e-mail to DataProtectionOfficer@AIG.com or by post to Data Protection Officer, AIG Europe Limited, The AIGBuilding, 58 Fenchurch Street, London EC3M 4AB.

CLAIMS DECLARATION

1. I / we give permission for my / our personal information to be used and shared in the ways described above
2. I / we confirm that I / we will not provide any personal information about another person without that person's permission, and that where a claim is made on behalf of that person, I / we have their explicit authority to act and receive any payment on their behalf.
3. I / we declare that all the information given in respect of the claim(s) is to the best of my / our knowledge and belief, full, true and correct, and that no material information has been omitted which would affect the assessment of the claim(s) by the insurer(s).
4. I / we understand that if I / we give information that is incorrect or incomplete you and / or the insurer(s) may take action against me / us, including court action.
5. I / we know it is a CRIMINAL offence to defraud, or attempt to defraud an insurer and that by doing so I / we may be prosecuted.
6. I / we give my / our authority to you to contact my / our household insurers, medical insurers, DWP or other insurers / third parties regarding a contribution.
7. In the event of a medical related claim I/we give my/our authority to contact and obtain information from my/our GP, Doctor, Hospital or other medical facility or practitioner.

I / we have read and fully understand the declarations above (ALL persons claiming must sign below).

Claimants name	Claimants signature	Date of birth	Dated

Cancellation, page 1.

Claim Ref:

Reason for cancellation - please tick ONE box only

Death ☐	Illness ☐	Injury ☐	Non medical ☐

Date and time you became aware of the need to cancel your trip: / /

Date and time you informed your travel agent or tour operator: / /

Did you need to cancel as a result of a person NOT booked to travel with you? YES NO

If YES, please state their name and relationship to you.

Name: Relationship:

Details of trip costs and refunds due or paid (continue on a separate sheet if necessary).

	Amount Paid		Refund due or paid		Total amount claimed
Ticket costs					
Accommodation costs					
Pre-paid excursions / hire car / parking					
Total		-		=	

Details of all those cancelling (continue on a separate sheet if necessary).

Name	Relationship	Date of birth	Insured on this policy?
		/ /	YES / NO
		/ /	YES / NO
		/ /	YES / NO
		/ /	YES / NO
		/ /	YES / NO

Please detail the reasons for cancellation below (continue on a separate sheet if necessary).

Was a 3rd party involved? YES NO

If YES, please provide their name, address and their insurance/solicitors details:

Cancellation page 2.

Claim Ref:

Are the expenses insured by any other policy you have? Such as travel agent, bank account or credit card policy? **YES** **NO**

PLEASE NOTE: Where 2 policies cover the same loss it is normal practise for both insurers to share the cost. This will not affect any no claims discount or premium for that policy.

If YES, please supply the following details:

Insurer name

Insurer address

Policy number

Telephone number

Details of any previous claims made on a household or travel insurance policy for similar circumstances.

Have these insurers been notified? **YES** **NO** If yes, give details and the claim reference number below:

Access to Medical Records Act, 1988/Access to Personal Files and Medical Reports. (Northern Ireland) Order 1991/Access to Health Records and Reports Act 1993. (Isle of Man) ("The Acts")

To enable Travel Guard EMEA Limited to assess your claim, it may be necessary to obtain medical evidence. Any reports which are requested from your doctors are subject to the Acts. (Please note that Reports requested from Doctors appointed by Travel Guard EMEA Limited are not subject to the Acts). In summary your statutory rights are as follows.

1. A Medical Report cannot be requested from any doctor who has attended you, without your written authority.

2. You do not have to give your consent. If you do consent, you can say whether you wish to see the report before it is supplied. If you do not give consent we may be unable to proceed with your claim.

3. If you say you wish to see the report, we will write to your doctor and tell them, and advise you that we have done so. You will then have 21 days from the date of notification to contact the doctor to make arrangements for you to see the report.

4. The medical practitioner will be informed that you wish to have access to the report and will allow 21 days from the date of the notification for you to see and approve it before it is supplied to us. If the medical practitioner has not heard from you in writing within 21 days of the application for the report being made he/she will assume that you do not wish to see the report and that you consent to it being supplied.

5. If you say that you do not wish to see the report, we do not have to notify you if we apply for one.

6. Whether or not you say you wish to see the report before it is sent to us, you may ask your doctor to show you a copy of the report for up to 6 months after it is supplied. The practitioner may charge a reasonable fee for the cost of supplying a report not exceeding £50.

7. If you see a report before it is sent to us, the doctor cannot submit it until you give your consent. You can write to the doctor, asking that any part of the report which you consider to be incorrect or misleading be amended and to have attached to the report a statement of your views on any part where you and the doctor are not in agreement.

8. The doctor is not obliged to let you see any part of a report if,

   a) In his/her opinion it would be likely to cause serious harm to your physical or mental health, or that of others.

   b) It would indicate the doctor's intentions towards you.

   c) Disclosure would be likely to reveal information relating to, or the identity of, someone else that has supplied information about you, unless that person has consented.

Your Regular GP:

Address:

Telephone:

Fax:

DECLARATION. I DECLARE THAT ALL THE INFORMATION GIVEN IS TO THE BEST OF MY KNOWLEDGE AND BELIEF, FULL, TRUE AND CORRECT, AND I UNDERSTAND THAT IF I GIVE INFORMATION THAT IS INCORRECT OR INCOMPLETE YOU MAY TAKE ACTION AGAINST ME, INCLUDING COURT ACTION.

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 DO NOT wish to see the records before they are sent to Travel Guard EMEA Limited.

☐ I DO wish to see the records before they are sent to Travel Guard EMEA Limited.

Patient's Signature

Date:

Full Name

Medical Certificate

Claim Ref:

This form is to be completed by the registered General Practitioner (GP) of the person whose illness/injury/death has caused the claim.

Note - Any charge made for its completion is the responsibility of the patient or claimant.

- Please answer all questions. Ticks, dashes, "N/A" are not acceptable. Please complete in CAPITALS.

- All information is treated as private and confidential.

TRIP BOOKING DATE:

Name of the patient:

Date of birth:

How long have you been the patients GP?

Give full description of illness or injury that caused the cancellation:

Onset date of symptoms:

Date first consulted:

Date of diagnosis:

In date order, please advise any previous medical history relevant to the above condition.

At the time that the trip was booked, was the person receiving, or on a waiting list for, or recovering from in-patient treatment in a hospital/nursing home? YES NO

If YES, Please provide details:

At the time the journey was booked was the patient

On a hospital waiting list?	YES NO	
Taking any medication relevant to the above condition?	YES NO	
Undergoing any tests or waiting for results of any tests?	YES NO	
Aware of the condition?	YES NO	
Given a terminal diagnosis?	YES NO	

If cancellation has occurred due to a pregnancy related condition, please describe the condition and why the pregnancy necessitates cancellation:

Date pregnancy confirmed:..... E.D.D:.....

What date did it became apparent that the travel arrangements should be cancelled?

What date did you advise there was a need to cancel the travel arrangements?

When would they be fit to travel again?

(ii) Has the patient been signed off work? YES NO From To

Please provide the patient's state of health at the time the holiday was purchased:

Was the patient's medical condition stable and under control at the time of booking? YES NO

GP DECLARATION

I have examined the patient and/or referred to their medical records and declare that the information given is correct and no relevant details have been withheld.

GP Name:

Contact number:

GP Signature:

Date Signed:

Surgery Stamp

BACS Payment Request Form

Claim Ref:

We are keen to encourage customers who are entitled to payment in respect of a claim to consider receiving their payment by bank transfer. If you do not want to receive payment by bank transfer then please do not complete the form below. If you do not complete the form below then we will send you a cheque for the relevant amount.

There are a number of advantages in receiving payments by bank transfer:

Payments are made directly into your bank account

Payments are received more quickly

If you wish us to make claims payments directly to your bank account, please complete the following bank transfer payment request fields and mail it with your accompanying claims documents

Your Name:

Your Address:

Contact Tel:

Details of the account you want your claim settlement paid into:

You should ensure that your payment details are correct on this form. We shall not be responsible for any incorrect payments arising as a result of the provision of incorrect information. We cannot accept responsibility for the security of the information on this form until it is received by us.

Name of the account holder

Name of the bank

Address of the bank:

For transfers within the United Kingdom

Sort Code: - -

Account Number:

For International transfers only (outside the United Kingdom)

IBAN (International bank account number)

SWIFT / BIC Code

Currency

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- to comply with any legal requirement on us or other companies in our group
- to make decisions about you and other people when selling insurance

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If you give information to us about another person, you will obtain that person's permission beforehand to provide the information and for us to use it as described above.

You can obtain further information by writing to our Data Protection Officer by e-mail to DataProtectionOfficer@AIG.com or by post to Data Protection Officer, AIG Europe Limited, The AIG Building, 58 Fenchurch Street, London EC3M 4AB.

SIGNED:

DATE: