ACE European Group Limited
Travel Insurance Claims
PO Box 1086, Belfast, BT1 9ES
tel: 0800 519 9940 or +44 (0)1293 726 165

Claim Form

CANCELLATION, CURTAILMENT OR REARANGEMENT

PLEASE WRITE IN BLACK INK AND USE BLOCK CAPITAL LETTERS.
ALL SECTIONS MUST BE COMPLETED OR MARKED 'NOT APPLICABLE'.
COMPLETE THE CHECKLIST AND ENSURE THAT YOU SIGN THE DECLARATION AT THE END OF THIS FORM.

POLICY NUMBER		
MAIN POLICYHOLDER DETAILS		
TITLE	FIRST NAME	LAST NAME
e-MAIL ADDRESS		DATE OF BIRTH (DD/MM/YYYY)
FULL ADDRESS		
		POSTCODE
CONTACT NUMBER (DAYTIME)	CONTACT NUMBER (EVENING)	

INSURED PERSONS DETAILS			
FULL NAME	DATE OF BIRTH (DD/MM/YYYY)	RELATIONSHIP TO MAIN POLICYHOLDER	I INTEND TO CLAIM ON BEHALF OF: (✓) where applicable
MAIN POLICYHOLDER AS ABOVE			

ACCESS TO MEDICAL REPORTS ACT 1988 BEFORE YOUR ATTENDING DOCTOR CAN GIVE A MEDICAL REPORT ON THIS CLAIM FORM WHICH IS A REQUIREMENT OF THIS CLAIM, YOU MUST GIVE YOUR CONSENT.
BEFORE GIVING YOUR CONSENT, YOU SHOULD BE AWARE OF YOUR RIGHTS UNDER THE ACT WHICH ARE SUMMARISED AS FOLLOWS:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading. If the Doctor does not agree with your request you may attach your comments to the report.

NB: The Doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it.

PATIENT DECLARATION

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to ACE seeking medical information from any Doctor who at any time has attended me concerning conditions which affect my physical or mental health.
2. I authorise such Doctor to disclose such information to ACE.
3. I agree that a copy of this consent shall have the validity of the original.

☐ I **DO** wish to see the report before it is sent to ACE
☐ I **DO NOT** wish to see the report before it is sent to ACE

SIGNED

DATE

TRAVEL DETAILS

Type of Travel: BUSINESS/HOLIDAY

Please give the reason for cancellation/curtailment/re-arrangement of the journey:

Please state the **scheduled** times of travel:

Outward Date: Return Date:

Date Journey Booked: Date of Cancellation/Curtailment/Re-arrangement:

PLEASE PROVIDE A COPY OF YOUR ORIGINAL ITINERARY/TRAVEL DOCUMENTS IF AVAILABLE

If the cancellation/curtailment/re-arrangement was due to **illness or injury** please state:

(a) the name and age of sick/injured person:

(b) the exact nature of illness/injury and the commencement date:

(c) has the person concerned previously suffered the same or a similar complaint? YES / NO

If YES please give the relevant dates:

If journey was **cancelled** please give details of expenditure incurred:

Total Amount Paid: Total Amount Refunded: Amount to be Claimed:

PLEASE PROVIDE A CANCELLATION INVOICE TOGETHER WITH YOUR TRAVEL DOCUMENTS FROM YOUR TOUR OPERATOR, TRANSPORT CARRIER OR ACCOMMODATION AGENT.

If journey was **curtailed** please provide details of additional travel and sundry expenses including how these were incurred:

RECEIPTS NEED TO BE ENCLOSED FOR THESE CHARGES.

PLEASE PROVIDE MEDICAL EVIDENCE FROM THE ATTENDING DOCTOR OR PLEASE ASK THE ATTENDING DOCTOR TO COMPLETE THE FOLLOWING:

Nature of complaint preventing travel:

Date treatment first sought:

Was cancellation of the journey medically necessary? YES / NO

VALIDATION STAMP

SIGNED: DATE:

PAYEE'S BANK DETAILS IF WE APPROVE YOUR CLAIM, WE CAN CREDIT THE MONEY DIRECT TO YOUR BANK ACCOUNT. THIS METHOD IS QUICKER, SAFER AND MORE RELIABLE THAN PAYMENT BY CHEQUE. IF YOU WOULD LIKE US TO DO THIS, PLEASE COMPLETE THE FOLLOWING:-

Name of your Bank/Building Society: ____________________

Address ____________________

Postcode ____________________

Bank Sort Code __ __ / __ __ / __ __

Account Number ____________________

Name of Account Holder(s) ____________________

DATA PROTECTION The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1998. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by ACE European Group Limited and its group companies. It may be held on computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

FOR SECURITY PURPOSES PLEASE PROVIDE A PASSWORD.
YOU WILL NEED THIS TO ACCESS YOUR CLAIM INFORMATION

PASSWORD:

DECLARATION I DECLARE THAT ALL THE INFORMATION GIVEN IS TO THE BEST OF MY KNOWLEDGE AND BELIEF, FULL, TRUE AND CORRECT.

SIGNED ____________________ DATE ____________________

CHECKLIST PLEASE RETURN THE COMPLETED CLAIM FORM TOGETHER WITH ANY ENCLOSURES TO ACE EUROPEAN GROUP LIMITED.

PLEASE ENSURE...

- ☐ YOU HAVE COMPLETED ALL RELEVANT QUESTIONS ON THIS CLAIM FORM
- ☐ YOU HAVE ENCLOSED ALL REQUESTED ORIGINAL DOCUMENTS (We recommend you retain copies)
- ☐ YOU HAVE SIGNED THIS CLAIM FORM
- ☐ YOUR ATTENDING PHYSICIAN HAS COMPLETED AND SIGNED WHERE APPLICABLE

IF YOU DO NOT COMPLETE ALL SECTIONS AND PROVIDE ALL REQUESTED DOCUMENTATION, YOUR CLAIM WILL BE DELAYED.

ACE European Group Limited, PO Box 1086, Belfast, BT1 9ES.
Registered in England No. 1112892. Head Office: ACE Building, 100 Leadenhall Street, London EC3A 3BP.
Authorised and regulated by the Financial Services Authority (FSA). Firm Reference Number: FRN202803.
Full details can be found on the FSA's Register by visiting www.fsa.gov.uk/pages/register or by contacting the FSA on 0300 500 5000 (call rates may vary).