CANCELLATION CLAIM FORM

Please complete all relevant sections of this Claim Form and return to:
P J Hayman Claims Department, Stansted House, Rowlands Castle, Hampshire PO9 6DX
Email: claims@pjhayman.com

Claim Number | | | | | | | | | | **(for office use only)**

If you require a large print version, please call **02392 419 020**
Please use **BLOCK CAPITALS** when filling in your form. If there is insufficient space for your answers please use the Additional Information box on page 4.

Check List of Required Documents

Please send the following to support your claim.
If you do not enclose all the documentation we have listed any settlement of your claim will be delayed.
Tick ✓ against documentation enclosed.

- ☐ Insurance Schedule (if you have an Annual Insurance a copy would be sufficient).
- ☐ Medical Pre-screening Confirmation (if applicable).
- ☐ Holiday Booking Invoice showing the date the holiday/trip was booked, who was booked to travel, travel dates, destination, amounts paid and purchase of your travel insurance (if applicable).
- ☐ Holiday Cancellation Invoice showing the date that the holiday/trip was cancelled, who has cancelled, the cancellation fee and the amount of refund that you will be receiving (if any).
- ☐ The Medical Certificate (on page 3), completed by the USUAL GP of person causing the cancellation. Please note this document must be completed by the usual GP, a hospital letter or certificate will not be accepted by Underwriters.

Please Note - scan & photocopies are acceptable, however, we do always encourage you to retain the original documentation in case we require any particular documents to be sent in for inspection or retention. Examples where this would be required are high value claims (for prevention of fraud) where we are required to retain originals for a certain period of time.

Claimant/Contact Details:

Claimant Name: | Claimant Age:
Name of Person handling the claim: (if different to above)
Address for Correspondence:
Postcode: | Tel No:
Email address:

Trip Details:

Outward Journey Date: D D M M Y Y | Return Journey Date: D D M M Y Y
Country: | Destination:

Insurance Policy Details:

Name of Travel Insurance: (e.g. Travel Plus)
Travel Insurance Policy Number: | Date Insurance Purchased: D D M M Y Y
Medical Screening Reference:
Please enclose the Medical Screening Confirmation – if applicable

Other Insurance Policies:

Do you hold any other insurance policy that may cover your claim ? ☐ Yes ☐ No
(e.g. BUPA, bank account or credit card)
If yes, please give details

Names of people claiming under this insurance:

1.	2.	3.
4.	5.	6.

Details of amounts paid for the trip:

Deposit	£ :	Date Paid D D M M Y Y
Balance	£ :	Date Paid D D M M Y Y
Amount refunded by your tour operator, travel agent, etc	£ :	Date Paid D D M M Y Y
Insurance premium paid (Note: this is not refundable)	£ :	Date Paid D D M M Y Y
Total amount claimed (cancellation charge)	£ :	

Cancellation Due To Medical Reasons:

Description of injury/illness causing Cancellation:

Name of Person causing the Cancellation:

Your relationship to them:

P J Hayman & Company Limited may need to contact the GP who has completed the medical certificate, should further clarification be required. Please confirm that this is in order by providing the patient's signature below.
Note: Fees charged may not be considered by the policy.

Signature Of Patient:

Cancellation Due To Other Reasons:

Please state reason:

- If cancellation is due to **redundancy** please provide us with a letter from your employer confirming that you qualify for statutory payment under the Employment Protection Act.
- If cancellation is due to your **Jury service** please provide us with your Jury Confirmation letter showing us when you were notified of the Jury service and the dates you are required to attend court.
- If cancellation is due to **any other reason**, we may request additional independent confirmation of the need to cancel.

Date you cancelled your holiday/trip: Date: D D M M Y Y

How did you advise cancellation? By Phone: ☐ In Writing: ☐ In Person: ☐

Settlement Method - Claims are paid by Cheque or Bank Transfer
Where a majority of our insurers will use Bank Transfer, please complete the below to prevent us asking for this at a later date:

Bank Name/Address

Sort Code

Name on Account

Account Number

Declaration

I declare that to the best of my knowledge and belief all information provided is correct. I understand that some of the information I have provided will be made available to other insurers for claims handling purposes. I consent to the seeking of information from other insurers to check the answers I have provided and I authorise the giving of such information. I agree that I will supply all requested, necessary documents in support of my claim at my expense.

Signature: Date: D D M M Y Y

Medical Certificate

This certificate is to be completed in BLOCK CAPITALS by the usual treating GP of the person causing the cancellation. Medical Certificates completed by a hospital will not be accepted.

Note: any fee incurred to complete the Medical Certificate may not be considered by the policy.

Name of patient: Age: Date of Birth: D D M M Y Y

Are you the patients usual GP: Yes No How long has the patient been with the practice: Years Months

Precise nature of illness/injury causing cancellation of the holiday/trip:

Are you prepared to certify that solely due to the condition described above, the claimant(s) are compelled to cancel? Yes No

Is the above condition directly or indirectly related to any known pre-existing condition? Yes No

If yes, please provide details of the condition:

Date illness / injury causing your claim: D D M M Y Y

Date & time you were first consulted: hrs D D M M Y Y

Date referred to a consultant (if applicable): D D M M Y Y

Date wait listed for operation (if applicable): D D M M Y Y

Date admitted to hospital (if applicable): D D M M Y Y

Date discharged from hospital (if applicable): D D M M Y Y

Claims due to pregnancy

Date confirmed: D D M M Y Y

Expected due date: D D M M Y Y

The reason why the pregnancy necessitates cancellation of the holiday/trip:

Date you advised the patient to cancel: D D M M Y Y

If you did not advise the patient to cancel, on what date did the cancellation become medically necessary? D D M M Y Y

If possible, please indicate when the patient would be fit to travel? D D M M Y Y

Has a terminal prognosis been made? Yes No If yes, when was the patient made aware of this? D D M M Y Y

In the last 12 months has the patient been fit and well enough to travel? Yes No

If no, please provide details:

Were you advised of the planned trip? Yes No

If yes, please provide date: D D M M Y Y

If advised, were there any circumstances which could have reasonably been anticipated to give rise to a claim? Yes No

If yes, please provide details:

If the response to any of the following questions is YES please provide details of the Condition and the Date of Diagnosis in the spaces provided. Please use the Additional Information box below if you need more space for your answers.

In the last 5 years has the patient been treated (including prescribed medication) for any:

- respiratory condition (relating to the lungs or breathing);		D D M M Y Y
- heart or heart related condition;		D D M M Y Y
- circulatory condition (relating to the blood or circulation);		D D M M Y Y
- kidney or renal condition;		D D M M Y Y
- liver condition;		D D M M Y Y
- condition relating to the pancreas e.g. diabetes;		D D M M Y Y
- cerebral or neurological condition (relating to the brain);		D D M M Y Y
- type of cancer;		D D M M Y Y
- type of stroke;		D D M M Y Y
- central nervous system disorder;		D D M M Y Y
- irritable bowel disease;		D D M M Y Y
- psychiatric or psychological conditions.		D D M M Y Y

Received any surgery, inpatient or outpatient treatment or had any tests or investigations in a hospital or clinic or been seen by a specialist consultant within the last 2 years?		D D M M Y Y
Been prescribed medication for any medical condition in the last 2 years?		D D M M Y Y
Has there been any change in medication within the last 6 months?		D D M M Y Y

Address Stamp

I have examined the patient and referred to their medical records and I declare that the information given is correct and that no details relevant to this case have been omitted.

Name:

Qualifications:

Signature: Date:

Additional Information: