

Names of people claiming under this insurance:

1. <input type="text"/>	2. <input type="text"/>	3. <input type="text"/>
4. <input type="text"/>	5. <input type="text"/>	6. <input type="text"/>

Details of amounts paid for the trip:

Deposit	£ <input type="text"/> : <input type="text"/>	Date Paid	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
Balance	£ <input type="text"/> : <input type="text"/>	Date Paid	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
Amount refunded by your tour operator, travel agent, etc	£ <input type="text"/> : <input type="text"/>	Date Paid	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
Insurance premium paid (Note: this is not refundable)	£ <input type="text"/> : <input type="text"/>	Date Paid	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>				
Total amount claimed (cancellation charge)	£ <input type="text"/> : <input type="text"/>									

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. Any fees will 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: | |

How did you advise cancellation?

By Phone: In Writing: In Person:

Settlement Method - Please indicate your preferred method to receive settlement payments:

Cheque Bank Transfer

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: | |

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.

Any fee incurred to complete the Medical Certificate is not covered under the insurance policy.

Name of patient: Age: Date of Birth:

Are you the patients usual GP: 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: Date referred to a consultant (if applicable):

Date & time you were first consulted: hrs Date wait listed for operation (if applicable):

Date admitted to hospital (if applicable):

Date discharged from hospital (if applicable):

Claims due to pregnancy Date confirmed: Expected due date:

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

Date you advised the patient to cancel:

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

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

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

Please give details of previous medical history:

When the holiday/trip was booked on the were you consulted? Yes No

Was the booking contrary to medical advice? Yes No

If yes, please provide details:

On the above date was the patient fit and well? Yes No

If no, please provide details:

When the insurance was purchased on the were you consulted? Yes No

On the above dates were there any set of circumstances which could have reasonably been anticipated to give rise to a claim? Yes No

If yes, please provide details:

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:	<input type="text"/>
	Qualifications:	<input type="text"/>
	Signature:	<input type="text"/> Date: <input type="text"/>

