

 Cancellation/Curtailment Claim Form

 THANK YOU FOR NOTIFYING US OF YOUR CLAIM

 PLEASE COMPLETE ALL QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE "N/A"

UNIVERSITY OF YORK

Policy No: 100003637GPA

Date on which Travel commenced or was due to commence:

Full Name of Person Covered: Date of Birth:

Title (Mr, Mrs, Miss, Ms, Dr, Prof): Job Title:

Nationality:

Full Address:

Postcode:

Tel No. (Business): (Home):

Email:

Full Names of other Persons Covered Date of Birth Relationship

1.

2.

3.

PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS CLAIM FORM

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| **TRAVEL DETAILS** |
| Type of Travel: Business/Holiday |
| Please give the reason for the cancellation/curtailment of the journey. |
| Please state the schedules times of travel:Outward Date: Return Date:Date Journey Booked: Date of Cancellation/Curtailment:**Please provide a copy of the original itinerary/travel documents** |
| If the cancellation/curtailment was due to illness or injury, please state:1. The name and age of sick/injured person:
2. The exact nature of illness/injury and the commencement date:
3. Has the person concerned previously suffered the same or a similar complaint? YES/NO If YES, please give the relevant dates:

**Please provide medical evidence from the attending doctor or please ask the attending doctor to complete the following:****Validation Stamp:**Nature of complaint preventing travel: Date treatment sought:Was cancellation of the journey medically necessary? YES/NOSigned: Date:  |
| 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, transporter 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.** |

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| **DATA PROTECTION** |
| Information You or the Insured Person supplied may be used for the purposes of insurance administration by Us, its associated companies and agents, by reinsurers and Your intermediary. It may be disclosed to regulatory bodies for the purposes of monitoring and/or enforcing of Our compliance with any regulatory rules/codes. Your and the Insured Person(s) information may also be used for offering renewal, research and statistical purposes and crime prevention. It may be transferred to any country, including countries outside the European Economic Area for any of these purposes and for systems administration. In assessing any claims made, We or Our agents may undertake checks against publicly available information (such as electoral roll, county court judgements, bankruptcy orders or repossessions). Information may also be shared with other insurers either directly or via those acting for the Us (such as loss adjusters or investigators).With limited exceptions, and on payment of the appropriate fee, You or the Insured Person have the right to access and if necessary rectify information held. |

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| **DECLARATION** |
| I declare that the information given is to the best of my knowledge and belief, full, true and correct.Signed: Date:  |

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| **ACCESS TO MEDICAL REPORTS ACT 1998** |
| Before a doctor can give a medical report on this claim form, which is a requirement of this claim, the Person Covered must give their consent. Before giving consent, they should be aware of their rights under the Act which are summarised as follows:**PATIENT DECLARATION**1. They may withhold their consent. Having been made aware of my statutory rights under the

Access to Medical Reports Act 1998 in connection with my1. They may see the report before it is sent to us claim within 21 days from the date of this report.
	1. I hereby consent to Aviva seeking medical information
2. They may ask to see the report for up to six months from any doctor who at the time has attended me After the report is completed. concerning conditions which affect my physical or

mental health.1. They may ask the doctor to amend any part of the 2.

Report which they consider to be incorrect or I DO wish to see the report before it is sent Misleading. If the doctor does not agree with their request the Person Covered may attach their I DO NOT wish to see the report before it is comments to this report. 3. I authorise such doctor to disclose such information NB The doctor may withhold all or part of this report From the Person Covered if he considers that they 4. I agree that a copy of this consent shall have the validity may be physically or mentally harmed by it. of the original.Signed: Date:  |

PLEASE ENSURE

You have completed ALL relevant questions on this claim form. You have enclosed all requested information/documentation.

You have signed this claim form.

Failure to do so will result in delay in handling you claim.

Please return the completed claim form together with any documentation to:

insurance-enquiries@york.ac.uk

**Thank you for fully completing this form.**