

# CANCELLATION CLAIM FORM



Please complete all relevant sections of this Claim Form and return to:  
**PJ Hayman Claims Department, Stansted House, Rowlands Castle, Hampshire, PO9 6DX.**

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

Please use BLOCK CAPITALS when filling in your form. If there is insufficient space for your answers please use the Additional Information sheet on page 4.

## Check List of Required Documents

Please send **Originals** (you may retain copies for your records).

If you do not enclose all the documentation we have listed any settlement of your claim may 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.

**Originals** - Please note that photocopies are not acceptable when processing your claim we must have the original documents. Some original documentation can be returned, if requested, once settlement is made.

Name:  Age:   
Address:   
 Postcode:

## Details of person handling the claim if different from above:

Name:   
Address:   
 Postcode:

## Planned Travel Dates:

Outward Journey Date:  Return Journey Date:

Name of Travel Insurance: (e.g. Travel Plus)   
Travel Insurance Policy Number:  Date Insurance Purchased:   
Medical Screening Reference:

*Please enclose the Medical Screening Confirmation – if applicable*

## Previous Insurance Losses:

Have you had any previous insurance losses in the past 5 years (e.g. household, travel, motor)?

If **yes**, please provide details of the loss, together with the name of the insurance company and the claim number

**Other Insurance Policies:**

Do you hold any other insurance policy that may provide you with additional cover for your cancellation (e.g. BUPA, etc)?

If yes, please give details

**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"/>	<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"/>	<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"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Insurance premium paid ( <b>Note:</b> this is not refundable)	£ <input type="text"/> : <input type="text"/>	Date Paid	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>Total amount claimed (cancellation charge)</b>	<b>£ <input type="text"/> : <input type="text"/></b>	Date Paid	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<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:

PJ 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.

**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:

**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.

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.**

Name of patient:  Age:  Date of Birth: 

D	D	M	M	Y	Y
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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: 

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

D	D	M	M	Y	Y
---	---	---	---	---	---

Date & time you were first consulted:  hrs 

D	D	M	M	Y	Y
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 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
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## Claims due to pregnancy

Date confirmed: 

D	D	M	M	Y	Y
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 Expected due date: 

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

Date you advised the patient to cancel: 

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

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

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

D	D	M	M	Y	Y
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General state of health in the last 12 months:

Please give details of previous medical history and dates of consultations:

Is the patient suffering from any chronic disease, illness or from any physical defect or infirmity?  Yes  No

If yes, please give details:

When the holiday/trip was booked on the 

D	D	M	M	Y	Y
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 were you consulted?  Yes  No

Was the booking contrary to medical advice?  Yes  No

If yes, please provide details:

When the insurance was purchased on the 

D	D	M	M	Y	Y
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 were you consulted?  Yes  No

On the above two dates was the patient fit and well?  Yes  No

If no, please provide details:

On the above two 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	<p>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.</p> <p>Name: <input style="width: 100%;" type="text"/></p> <p>Qualifications: <input style="width: 100%;" type="text"/></p> <p>Signature: <input style="width: 100%;" type="text"/> Date: <input style="width: 100%;" type="text"/></p>
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