

CURTAILMENT CLAIM CHECKLIST

The attached claim form and relevant documents from the checklist below should be sent to us if you have had to return home from your holiday or trip earlier than planned and wish to make a claim under your travel insurance policy. This list is not exhaustive and we may ask for further evidence once we review your claim. A claim number will be notified to you once we have validated your details.

Proof of insurance and any medical endorsements –

POLICY OR CERTIFICATE OF TRAVEL INSURANCE / VALIDATION CERTIFICATE - your claim will be delayed if you do not submit this. (Please note this is NOT the ATOL certificate) We do not need the policy booklet.

Employer's details and policy number where you are insured under a company scheme, insurance reference number etc.

Proof of travel –

This must show total cost of the trip, the names of all passengers, the date of booking and the travel dates and come from the tour operator or airline. If you booked independent arrangements (i.e. car hire, travel tickets, accommodation etc.) please send the booking invoice for each item

If you booked your trip over the internet please ALSO send copies of the confirmation emails you received

If you booked your trip through a travel agent please ALSO send copies of the agents booking confirmation

Evidence to support the claim –

Medical Certificate completed by the USUAL GP of the non-travelling person whose illness or injury caused the curtailment. **We are sorry but we cannot accept the medical certificate completed by anyone other than the usual GP of the person causing the curtailment**

Medical report issued by the overseas treating doctor advising of the need to return early

The original death certificate (which we will return) or a certified copy

If the deceased was insured under this policy we will require a copy of the Grant of Probate

Unused tickets –

Tickets and invoices relating to any unused pre booked excursion, theme park entrance, activity, ski pass, theatre tickets etc. for which you are claiming

Additional travel & accommodation costs –

Hotel/accommodation invoice showing dates, costs and names of guests. Travel tickets / invoice showing date, cost and passenger names

Third party responsibility –

Name, address and general information about the person or company whom you feel was responsible for your illness or injury. Photographic evidence should be provided if available. Police report if applicable. Details of any solicitor or company you have appointed to handle a personal injury claim on your behalf

Armed forces withdrawal of leave –

Your commanding officer must provide a letter confirming that your planned leave was authorised and subsequently withdrawn. This must include the date you were first notified and the reason why leave has been withdrawn

Non-specified curtailment –

For curtailment reasons not mentioned above please provide relevant and appropriate documentary evidence of the need to return home early. Please call us for further guidance if you are unsure

Other insurance –

If you have submitted a claim connected to this one to another insurance company please send copies of all correspondence

To help you with your claim our FAQs can be viewed at www.reactiveclaims.com

Reactive Claims

Attwood House | Mansfield Business Park | Four Marks | Hampshire | GU34 5PZ
Main Office: 01420 383010 | Fax: 01420 558111 | Web: www.reactiveclaims.com

MEDICAL CERTIFICATE

Please complete questions **13 & 14** before passing this form to your GP.
Please answer ALL questions in full, using **BLOCK CAPITALS**.

This form is to be completed by the USUAL GP of the person causing the cancellation, whether travelling or not. This must be the USUAL GP and NOT a hospital consultant or medical specialist as the GP will have full access to previous medical history records which will be required to ensure the medical certificate is completed correctly. Charges made for the completion of this form are NOT claimable under this insurance.

1. Full name of person to whom these medical details apply:			
2. Date of birth: / /	3. Age:	4. Relationship to claimants:	
5. Medical condition / injury / cause of death:			
6. Is regular medication taken for this condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide prescription details:			
7. Please provide details of any previous medical history of the above condition or other relevant condition:			
8. Is regular medication taken for any other condition? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide prescription details and state the relevant condition to which each medication refers:			
9. Exact date of onset of symptoms for this condition: / /		10. Date GP first consulted: / /	
11. Date it first became apparent of the need to cancel: / /		12. Date you advised the need to cancel: / /	
13. Date insurance purchased: / /		14. Date trip booked: / /	
15. At the time the insurance was purchased and the trip booked (<i>Q13 & Q14 refers</i>) please state whether:			
a) The condition was under control <input type="checkbox"/> Yes <input type="checkbox"/> No			
b) This was an exacerbation of an existing condition <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date of exacerbation / /			
c) The patient was on a waiting list for in-patient treatment or was an in-patient <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date / /			
d) The patient had received a terminal prognosis <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, give date / /			
e) If the patient was travelling, the condition was a contra indication to do so <input type="checkbox"/> Yes <input type="checkbox"/> No			
f) The patient had previously been advised <u>AGAINST</u> travel <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details:			
16. Was the treatment / surgery prescribed for this condition elective? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please provide details:			
17. Pregnancy ONLY –			
a) Date of LMP: / /		b) Date pregnancy confirmed: / /	
		c) EDC: / /	
d) Exact medical condition preventing travel:			
<p>GP's DECLARATION</p> <p>I certify that the cancellation was due solely to the medical conditions stated. I declare that the information given is correct.</p> <p>Print name: _____</p> <p>Signature: _____</p> <p>Date: _____</p> <p>Qualifications: _____</p>		<p>Group practice stamp – <i>this form will be returned if this is not provided:</i></p> <hr/> <p>Practice name & address:</p>	

Please use the reverse of this form for any additional relevant information. Please indicate if you have done this Yes No