Notification Claim Form

Type Of Claim: _____

Contact Number: _____

Email Address: _____

Postal Address: _____

_____

_____

Important information / What next?

1. Please complete the attached claim form
2. Any additional notes/comments please attach to the back of this form
3. Please list supporting documentation that will be attached to this claim form: a) _____

   b) _____

   c) _____

   d) _____

   e) _____

   f) _____
4. Please post the completed claim form along with any attachments to:

OSG
Merrion Hall
Strand Road
Sandymount
Dublin 4
Ireland

Policy Information:

Policy Number: _____

Purchased from: _____

Type of Policy: _____

Dates covered: _____

Additional Cover:

Notification Claim Form

Medical Conditions:

Endorsements:

Claimant Details:

Full Name:	Date of Birth:	Job Title:	Nationality:	Place of Birth:

Travel Details:

Date of booking the trip:

Departure Date:

Return Date:

Destination Country:

Purpose of trip:

What are you claiming for?:

Amount: €

Cancellation Claim Form

Reason for cancellation – please tick ONE ☑ ONLY

Death ○ Illness ○ Injury ○ Non Medical ○

If the reason for cancellation is medically related, the attached medical certificate MUST be completed by the usual General Practitioner for the person whose condition caused cancellation of the trip.

1. Date and time you became aware of the need to cancel your holiday ___ /___ /___

   Time: _____

2. Date and time you informed your travel agent or tour operator of the need to cancel your holiday: ___ /___ /___

   Time: _____

3. Details of holiday cost and cancellation charges

   Package holiday ○

   Independently Booked ○

   Ticket costs: €

   Accommodation Costs: €

   Pre-Booked Excursions: €

   Other Expenses (i.e. / Car parking, Airport Hotels, Transfers): €

   Deducted refunds received or advised: €

   Total amount claimed: €

Please confirm how you paid for your holiday i.e.) cash, credit card or debit card, If paid via credit card please provide copy of the statement showing the payment made.

4. Name and dates of birth of all those cancelling the trip:

Title	Full names	Date of Birth	Occupation

Cancellation Claim Form

5. Please detail the reasons for cancellation below:

Please complete one of the following if applicable to the cause of the cancellation:

a) Redundancy: ○

Date advised of redundancy: ___ /___ /___

Redundancy commencement date: ___ /___ /___

Year you joined the company: _____

Please confirm if paid on a PAYE basis: Yes ○ No ○

You will need to send the ORIGINAL letter from your employer confirming your redundancy

b) Road Traffic Accident: ○

Date of RTA ___ /___ /___

Location: _____

Police incident/ report number: _____

Make of vehicle: _____

Model of vehicle: _____

Name and address of third party insurer: _____

You will need to enclose the ORIGINAL police report(s) of the incident

Cancellation Claim Form

c) Injury at work (or similar): ○ Date advised of incident: ___ /___ /___

Company name: _____

Company address: _____

_____

Name and address of company insurer: _____

_____

You will need to provide the ORIGINAL letter or report from your employer confirming the details of the incident

6) Do you hold any form of bank account / credit card that offers you complimentary travel insurance that covers the circumstances surrounding your claim? Yes ○ No ○

If YES, please confirm the following:

Card number:

Issuing Bank: _____

Card Type (Gold, Platinum, Premier): _____

Has a claim to a third party been submitted? Yes ○ No ○

If YES, please provide details: _____

_____

7) Is there any other relevant policy that may cover the circumstances surrounding your claim? Other policies, Barclaycard, Amex Yes ○ No ○

If YES, please provide details

If the claim is in relation to injury please confirm the following:

a) An outline of the circumstances giving rise to the accident

_____

_____

b) If a third party was involved the name and address of the Third Party and their insurance details if known

Cancellation Claim Form

c) In the event that you are pursuing a claim for damages against a Third Party please provide the name and address of any solicitor who may have been appointed and their reference number

d) If no Third Party was involved please clarify who or what was at fault and why

If your claim is agreed, please provide your banking details below for payment:

Confirm payee name:

Bank Name:

Bank Address:

Bank SWIFT Code:

Bank IBAN:

Account Number:

Sort Code:

Account Holder:

Type of Account (Premier, Gold, Platinum etc):

Declaration: IMPORTANT- Failure to sign will result in your claim form being returned.
I/we declare that the above statements are true and correct to the best of my/our knowledge and belief. I/we have not withheld any information within my/our knowledge connected with this claim. I/we agree to provide the insurer with any further information as may be reasonably required. I/we understand that the insurer does not admit liability by issue of this form.
WARNING – the making of a fraudulent or knowingly exaggerated claim is a criminal offence. We investigate all cases and any person suspected of fraud is reported to the police with whom we always co-operate.

Cancellation Claim Form

DATA PROTECTION ACT

The insurance industry operates a number of anti-fraud initiatives. The information given on this form may be stored electronically and may be shared with other organisations for this purpose. I/we understand that you may ask for information from other organisations to check the answers I/we have provided.

IMPORTANT

In the event of a third party being liable, all rights in this matter are subrogated to the travel insurance underwriters or their agents on all settlements of this claim.

Signature: _____ Date: ___/___/___

Medical Certificate

To be completed by medical practitioner

Please use BLOCK LETTERS

To be obtained at your expense from the patients General Practitioner in all cases of Curtailment or Cancellation Costs resulting from injury, illness or death.

Important: The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries.

1. Name of the Patient: _____

Date of birth: ___ /___ /___

2. Are you the patient's usual GP? Yes ◯ No ◯

If YES, for how long? _____

If NO, please provide full details of the patient's usual GP:

_____

_____

3a. Please give a precise diagnosis of the illness or injury or cause of death:

_____

_____

b. On what date did the patient first consult you with symptoms of this condition? ___ /___ /___

4. Date of the onset of the illness or injury: ___ /___ /___

5. Date tests prescribed: ___ /___ /___

6. Date tests carried out: ___ /___ /___

7. Date condition diagnosed: ___ /___ /___

8. Date referred to specialist: ___ /___ /___

9. Name and address of specialist/surgeon: _____

_____

_____ Postcode: _____

10. Has the patient received a terminal prognosis? Yes ◯ No ◯

Medical Certificate

If YES, please provide date and prognosis: ___ /___ /___

11. Have you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in question 3a? Yes ◯ No ◯

If YES

a. State the diagnosis of the previous illness/injury

b. Advise the date of the occurrence of the pervious illness/injury and advise what treatment/ medication was prescribed

c. Is the patient receiving any medical advice, treatment or medication for this condition or any similar/ related conditions? Yes ◯ No ◯

If YES, please provide details:

d. Please list all active medical conditions, date of diagnosis and details of medication, if any:

12. Has any other Medical Practitioner treated this patient for the same/ similar/related illness or injury as described in question 3a? Yes ◯ No ◯

If YES, please supply the name and address of the Doctor:

Postcode

13.Has the patient received in patient treatment for any conditions in the last 24 months? Yes ◯ No ◯

If YES, please provide details of treatment and when: ___ /___ /___

Medical Certificate

14. Pregnancy Only

a. Date of LMP: ___ /___ /___

b. Date of pregnancy confirmed: ___ /___ /___

c. Estimate date of confinement: ___ /___ /___

d. Exact medical condition within pregnancy:

15. Was the claimant required to cancel the travel arrangements solely due to the condition described in question 3a? Yes ◯ No ◯

16. On which date was it recommended that the patient cancel their travel arrangements? ___ /___ /___

17. If the dates in answer 7 and 16 differ, please provide explanation:

18.Had the patient planned to travel against your prior advice? Yes ◯ No ◯

If YES, please provide details:

I certify that the statements contained in this Medical Certificate are true and correct

Doctor's Signature: Date: ___ /___ /___

Doctor's name:

Medical Certificate

Qualification:

Postal address:

Postcode:

Business phone number:

Fax number:

Mobile phone number:

Email address:

Practice Stamp: