# CANCELLATION / LOSS OF DEPOSIT CLAIM FORM

Please submit your claim to **claims@optimumglobal.com**

Personal Data provided in this claim form or submitted as part of this claim will be used and processed by us in line with our Privacy Policy which can be found on our website, or which can be requested from us at any time.

## SECTION A: PATIENT DETAILS TO BE COMPLETED BY INSURED MEMBER

Name of Main Applicant: _____ Membership No.: _____ Date of Birth: _____ Sex: _____

Name of other claimants (If other than the main Applicant): _____ _____ _____ _____

Present Contact Address: _____

Telephone number: _____ Email Address for Remittance Advice: _____

## SECTION B: SETTLEMENT DETAILS

**We settle all eligible claims by bank transfer (EFT), therefore it is important that you confirm your correct bank details every time you make a claim. Should the incorrect bank details be provided we reserve the right to charge an administrative fee to cover any charges incurred due to the error.**

Total amount claimed (including currency): _____

Currency of Reimbursement: _____

Bank Transfer – **All fields in the box below are MANDATORY. If the account holder is not the claimant then you must state their relationship with the claimant and provide evidence of their permission for the funds to be transferred to their account (except in the case of a minor):**

Name of Account Holder (as it appears on bank statement): _____

Relationship to claimant _____

IBAN where applicable _____

Routing/intermediary information if required _____

Beneficiary Bank Account number (only if IBAN not applicable) _____

Account Holder address (residential address registered with the bank): _____

_____

Name of Bank, Branch and Location: _____

Swift Code/BIC: _____ Sort Code (for UK banks only): _____

**PLEASE NOTE:**

- **Bank charges may apply when making bank transfers.**
- **Payments are not made directly to any clinic, physician or medical provider.**
- **If IBAN numbers are not used please ensure that the account number is entered and that the Swift Code/BIC is also completed.**

## DECLARATION & AUTHORISATION

I declare that to the best of my knowledge all particulars contained in this form are true and correct. In the event of a third party being liable for loss/damage all rights in this matter are subrogated to Optimum Global on settlement of the claim. If cover exists under any other policy, I give my authority for contribution to be sought from their insurers. I understand that some of the information provided will be made available to other insurers for underwriting or claims handling purposes.

I certify that the above statements and answers are true and complete to the best of my knowledge and belief.

Signature of Main Applicant _____ Date _____

## SECTION C: TRAVEL DETAILS

**Travel Destination:**

Country: _____

Hotel: _____

Departure Date: ____/____/____ Return Date: ____/____/____

Purpose of Trip: ☐ Business ☐ Pleasure

## SECTION D: CLAIM DETAILS

Reason for the Cancellation: _____

_____

*If the reason for cancellation is medically related, the attached medical certificates **must** be completed by the usual Doctor of the person whose condition caused the cancellation of the trip.*

If the cancellation has been caused by a person not travelling and not insured on your policy, please state the relationship of that person to you:

_____

Date your insurance policy was purchased or renewed: ____/____/____

Period of Cover as stated on your travel insurance schedule: ____/____/____ to ____/____/____

Date you booked your trip: ____/____/____ Date you cancelled your trip: ____/____/____

Total deposit paid: £ _____ Date paid: ____/____/____

Total balance paid: £ _____ Date paid: ____/____/____

Total amount refunded: £ _____ Date refunded: ____/____/____

Total amount claimed: £ _____

Have you made any cancellation claims prior to this claim? ☐ Yes ☐ No

If **yes**, please give details: _____

Do you hold any travel insurance with your current bank account? ☐ Yes ☐ No

If **yes**, please give details: _____

Do you hold any travel insurance with the relevant tour operator? ☐ Yes ☐ No

If **yes**, please give details: _____

Did you use your credit card to pay for all or part of your trip? ☐ Yes ☐ No

If **yes**, please provide the relevant card statement showing the transaction: _____

Have you submitted a claim to any other insurer/authority? ☐ Yes ☐ No

If **yes**, please give details: _____

## SECTION E: MEDICAL CERTIFICATE

To be completed by the **General Practitioner** of the person causing cancellation (whether travelling or not). Any charge made for the completion of this document is the responsibility of the Insured Person and is not refundable by the Insurers.

**PLEASE NOTE: To avoid delay and unnecessary correspondence please complete this form in BLOCK CAPITALS and answer each question as fully as possible.**

| | | |
|---|---|---|
| 1) Full name of the person to whom these medical details apply | | |
| 2) Date of birth and Age | DoB: / / | Age: |
| 3) Are you his/her usual general practitioner?<br>If not, in what capacity are you involved? | ☐ Yes ☐ No | |
| 4) Please state the exact nature of illness/accident which made cancellation necessary. | | |
| 5) Is there any previous medical history of the above condition or other relevant condition?<br>If Yes, was the condition under control at the time of booking, please give details | ☐ Yes ☐ No | |
| 6) When did the patient first consult you with regard to this condition? | Date: / / | |
| 7) When was the condition diagnosed? | Date: / / | |
| 8) When was cancellation deemed necessary? | Date: / / | |
| 9) Were you aware of the travel plans when first consulted?<br>If NO, please confirm the first date on which cancellation could have been anticipated | ☐ Yes ☐ No<br>Date: / / | |
| 10) At the time the trip was booked, please state whether: | | |
| (a) This was an exacerbation of any existing condition and if so the date of exacerbation | ☐ Yes ☐ No | |
| (b) The patient was either on a waiting list for in-patient treatment or was an in-patient | ☐ Yes ☐ No | |
| (c) The patient had received a terminal prognosis | ☐ Yes ☐ No | |
| (d) If the patient was one of those travelling, the condition was a contra indication to do so | ☐ Yes ☐ No | |
| (e) Was travelling contrary to medical advice? | ☐ Yes ☐ No | |
| 11) PREGNANCY ONLY | | |
| (a) Date of LMP | Date: / / | |
| (b) Date pregnancy confirmed | Date: / / | |
| (c) Estimate date of confinement | Date: / / | |
| (d) Exact medical condition preventing travel | | |

| | |
|---|---|
| I certify that the cancellation was due solely to the medical conditions stated.<br><br>Name and Signature: _____<br>Qualifications: _____<br>Telephone Number: _____ | Practice Stamp |

## SECTION F: GUIDANCE NOTES

**The following documentation must be provided in order for your claim to be processed.**

| ITEM | ENCLOSED |
|---|---|
| Your original booking invoice which is sent to you at the time of booking your trip<br>If you have booked independent arrangements (i.e. car hire, airport hotel) then please provide us with a booking invoice for **each** item being claimed. | ☐ |
| Your original cancellation invoice which is sent to you at the time of cancelling your trip<br>If you have booked independent arrangements (i.e. car hire, airport hotel) then please provide us with a cancellation invoice for **each** item being claimed. | ☐ |
| Evidence of necessity to cancel your trip:<br>**Medical –** the attached medical certificate<br>**Redundancy –** redundancy notice confirming eligibility for redundancy package<br>**Court Attendance –** Court Subpoena | ☐ |
| Evidence of refund from tour operator/airline<br>If you have booked scheduled flights, all air taxes must be claimed from the airline | ☐ |
| If you have submitted a claim to another insurance company, copies of all correspondence | ☐ |