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† Standard national rates apply to all +44 (0) 1784 numbers. The customer service helpline is open 08:30 GMT - 18:00 GMT, Monday to Friday and 09:00 GMT - 13:00 GMT, Saturdays and UK public holidays. Bupa Travel Claims are open 09:00 GMT - 17:00 GMT, Monday to Friday. Calls may be recorded and may be monitored.

Address

IMPORTANT

Please keep a separate note of this claim reference number and quote it whenever you contact us.

Claim reference:

Date

Dear

Trip cancellation form

Thank you for requesting a claim form. Please ensure that you complete it fully and return it to us within 28 days of the end of your trip.

Please check that we have correctly stated your name, initial(s), address and post code and amend if necessary.

The section below details the documents which we need to deal with your claim and some notes which we would ask you to read carefully when completing the form.

Very important

Please ensure you enclose the following **original** (not photocopied) documents (if not already sent).

a) Evidence of your trip costs, such as the booking invoice showing the trip dates or travel tickets, ferry coupons, etc.

Yes No

Evidence of cancellation charges.

b) Either:

For all inclusive tours (package holidays) organised by a Tour Operator you must attach the Tour Operator's cancellation invoice showing cancellation charges levied and any refund made.

Yes No

or

For independently booked trips you must submit the unused travel tickets (or vouchers) together with official confirmation of the cancellation charges levied and any refunds made from the Airline/Ferry Company/Coach Company/Hotel.

Yes No

Claim form notes relating to medical cancellation

If the cancellation is due to medical reasons, please ensure the medical certificate on this claim form is fully completed by the patient's doctor. Failure to have the medical certificate completed will delay the processing of your claim. In the event of cancellation because of bereavement, please provide a photocopy of the Death Certificate.

Fast track claims

If you have no objection, in an effort to promote speedier and more customer friendly claims handling, we may find it easier to telephone and/or email you during the course of our normal working hours to discuss your claim and/or request further details.

If you do not wish to be contacted by either of these methods then please tick this box

Block capitals must be used please

1. Claimant's title: MR/MRS/MISS/MS/DR/OTHER (please circle)
Forenames: _____
Surname: _____

2. Address (P.O. Box addresses will not be accepted):

Post Code: _____
Country: _____

3. Contact
Daytime no.: _____
Evening no.: _____
Mobile no.: _____
Email: _____

4. Occupation: _____ Date of birth: _____

5. The country(ies) visited:

6. a) The schedule or member number:
b) For business schemes, please advise company name:

7. The period of your trip giving total number of days:
From: _____ To: _____
Total no. of days: _____

8. The date on which your trip was first booked
Day: _____ Month: _____ Year: _____
Purpose of trip: Business Leisure
(Please tick as appropriate)

9. a) Please advise the date on which you were advised to cancel: Day: _____ Month: _____ Year: _____
b) Please advise the date on which you gave cancellation instruction and how: Day: _____ Month: _____ Year: _____
i) Verbally ii) Written (including fax)
c) If the dates provided in 9(a) and 9(b) differ, please explain reason:

10. Please describe the exact circumstances which have caused you to cancel the holiday. Please continue on a separate sheet if necessary. If the reason for cancellation is not of a medical nature we will require documentary evidence to support the claim.

11. Please list all persons cancelling this trip who are insured by the policy. Please include their relationship to the person named on the medical certificate.

	Name	Relationship	Age
1.	_____	_____	_____
2.	_____	_____	_____
3.	_____	_____	_____
4.	_____	_____	_____
5.	_____	_____	_____
6.	_____	_____	_____

12. Was the person on the medical certificate due to travel on this trip? Yes No

13. Is this claim a result of an accident? Yes No
If you have answered yes, please complete this section including the solicitors details if applicable.
Brief details of accident: _____
Date of accident Day: _____ Month: _____ Year: _____
Solicitor name: _____
Address: _____ Postcode: _____

Medical certificate

The following medical certificate must be completed by the patient's usual GP or attending specialist.

Dear Medical Practitioner,

To avoid delay and unnecessary correspondence please complete this certificate (in block capitals), answering each question as fully as possible.

Any fee for completing this certificate is the responsibility of the patient/claimant.

14. Name of person to whom these details apply:

16. Age and date of birth:

15. How long have you been the Patient's GP?

17. Relationship to claimant (if known):

18. When did the patient first consult you with regard to this condition and please give date and time of diagnosis?

Date first consulted: _____ Date and time of diagnosis: _____

19. a) Please state exact nature of the illness/injury which made cancellation of the trip medically necessary and prevents travel:

b) Has the patient received a terminal prognosis?

Yes No

If yes, please provide date that terminal prognosis was given: Day: _____ Month: _____ Year: _____

c) Please provide details of any previous medical history relevant to the condition detailed in 19(a). Please include the original date of diagnosis and confirm the treatment/medication given and the date received:

e) Was the patient on a hospital waiting list for treatment for the condition which caused cancellation?

Yes No

If yes, please provide details and dates:

20. If cancellation has occurred due to a pregnancy related condition please describe the condition and why the pregnancy necessitates cancellation:

a) Date pregnancy confirmed: _____ b) E.D.D.: _____

21. Were you aware of the trip plans when you were first consulted?

Yes No

22. Please confirm the date that cancellation could have been reasonably anticipated: _____

23. Was the patient due to travel on the cancelled trip

Yes No

If yes a) Was the patient fit to travel on the date the trip was booked
Please refer to question 8 before answering this.

Yes No

b) Was the patient travelling contrary to medical advice?

Yes No

If no c) What was the patient's state of health on the date the trip was booked?
Please refer to question 8 before answering this.

I certify that the only reason for cancellation was due to the medical reasons stated above.

Name (print) _____

Signature _____

Qualifications _____

Date _____

Name and Practice Address (official stamp)

Failure to provide this information could delay your claim

Certain household contents policies provide an element of travel cover. Do you have household contents insurance policy or, if you are living with your parents, do they have a policy? Yes No

If yes, please supply the name and address of the insurance company and policy number.

Name: _____
Branch Address: _____
Policy No: _____

Do you have any other insurance which may cover this incident? Yes No

If yes, please supply details of the policy(ies)

Was a credit card used to pay all or part of the trip cost?

If yes, please supply the following information:

Name of card: _____ Cardholders name: _____
Name of card issuer (if different): _____ Credit Card No:

Please detail below the amount of the claim (excluding insurance premiums)

Independent arrangements
(Please state currency of payment)

Ticket cost: _____ Date paid: _____
Amount refunded: _____
Nett claim _____
Accommodation cost/
or other _____ Date paid: _____
Amount refunded: _____
Nett claim _____
Total amount claimed: _____

Package trips only
(Please state currency of payment)

Deposits paid: _____ Date paid: _____
Balance paid: _____ Date paid: _____
Total: _____
Deduct refund received: _____
Total amount claimed: _____

For office use only

Total. Total X/S. Total Nett.

Payment Method

Please choose the method by which you would prefer to receive payment.

Failure to complete this information may delay your claim.

Bank Transfer:
Account Holders Name: _____
Bank Name: _____
Bank Address: _____

Bank Account No: _____
Bank Sort Code: _____
BIC/Swift Code
(International customers only)
Cheque:

Data Protection Notice

Confidentiality. The confidentiality of patient and member information is of paramount concern to the companies in the Bupa group. To this end, Bupa fully complies with Data Protection Legislation and Medical Confidentiality Guidelines. Bupa sometimes uses third parties to process data on its behalf, such processing, which maybe undertaken outside the European Economic Area, is subject to contractual restrictions with regard to confidentiality and security in addition to the obligations imposed by the Data Protection Act.
Medical information. Medical information will be kept confidential. It will only be disclosed to those involved with your treatment or care, including your GP, or to their agents, and, if applicable, to any person or organisation who may be responsible for meeting your treatment expenses, or their agents
Member details. All membership documents and confirmation of how we have dealt with any claim you may make will be sent to the main member
Telephone calls. In the interest of continuously improving our service to members, your call may be recorded and may be monitored.
Research. Anonymised or aggregated data may be used by Bupa, or disclosed to others, for research or statistical purposes.
Fraud. Information may be disclosed to others with a view to preventing fraudulent or improper claims.
Names and addresses. Bupa does not make the names and addresses of members or patients available to other organisations.
Keeping you informed. Bupa would, on occasion like to keep you informed of Bupa products and services which it considers may be of interest to you
Contact address. If you do not wish to receive information about Bupa's products and services, or have any other Data Protection queries please write to the Bupa Group Information Protection Manager at Bupa House, 15-19 Bloomsbury Way London WC1A 2BA or at DataProtection@bupa.com.

Important

Please read the following carefully before signing the declaration

Please note that neither we nor the insurer are responsible for the costs of obtaining documentation in support of the claim.

The information on this form will be used by the insurers to deal with any claim. The insurer may also pass this to any other insurers and organisations involved in dealing with any claim. Insurers also share information to prevent fraud.

Declaration:

I/We declare that the information contained within this claim is true and correct to the best of my/our knowledge and belief.

I/We have not withheld any information from insurers within my/our knowledge connected with this claim.

I/We agree to provide any further information or documentation as may be reasonably required.

I/We give to insurers all rights of recovery / salvage any person or organisation and will do whatever else is necessary to secure such rights.

Signature of claimant: _____ Date: _____