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The customer service helpline is open 8.30am - 6pm, Monday to Friday and 9am - 1pm, Saturdays and UK public holidays. Bupa Travel Claims are open 9am - 5pm, 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. (If downloaded from our website, the claim reference number will be allocated when your claim form is received by 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. Page 4 of this claims form includes a declaration which you are required to read and sign. Failure to do so may cause delays in the processing of your claim.

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.

Please note this documentation must include the date when the trip was first booked.

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:

Post Code: _____
Country: _____

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

4. Occupation: _____ Date of birth: _____

5. The country(ies) visited/intended to visit:

6. a) The schedule or member number:

b) For business schemes, please advise us of the following.
The company name:
Name of the employee:
Relationship to claimant (if different):

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	Date of Birth
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 incident? Yes No
If you have answered yes, please complete this section.
Date of incident Day: _____ Month: _____ Year: _____
Brief details of incident _____
Do you consider anyone responsible for your incident? Yes No
If yes, please give details of the other party: _____

Medical certificate

The following medical certificate must be completed by the patient's usual GP or attending specialist in the event of a cancellation claim due to medical reasons.

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:

15. Age and date of birth of patient:

16. 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: _____

17. 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 17(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:

18. 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.: _____

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

Yes No

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

21. If the patient was due to travel on the cancelled trip:

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 the patient was not due to travel on the cancelled trip:

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: _____

Length of time you have known the patient: _____

Name and Practice Address (official stamp)

Failure to provide this information could delay your claim

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)

Package trips only (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: _____

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: Cheque:

Account Holders Name: _____

Bank Account No: _____

Bank Name: _____

Bank Sort Code: _____

Bank Address: _____

BIC/Swift Code

(International customers only)

If payment by cheque requested, please confirm the name of the payee: _____

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 may be 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.

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: _____

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