Curtailment Expenses
Claim Form

Please complete this claim form fully and return to us.
Please ensure that you quote your claim number on all correspondence.

Personal details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms Other

Family name First name

Date of birth D D M M Y Y Y Y N.I number

Address

Post code

Daytime tel no. Evening tel no

Email address Occupation

Policy details

Company name If applicable

Policy number Date of issue D D M M Y Y Y Y

Date of booking D D M M Y Y Y Y Destination

Date of travel D D M M Y Y Y Y Date of return D D M M Y Y Y Y

Travel agent Tour operator

Claim details

Reason for curtailment

Names of all persons who curtailed their trip	Age	Relationship to claimant

Actual date of return D D M M Y Y Y Y Number of unused nights

If curtailment was due to a medical condition of your party has a medical claim been submitted? ☐ Yes ☐ No

Was our medical emergency number contacted? ☐ Yes ☐ No

Date D D M M Y Y Y Y Time Claim number

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Particulars of claim

		Cost	
Nature of expenses	Provider	Local currency	Sterling

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Information we need from you for possible recovery opportunities

Your Travel Policy has conditions attached whereby you must provide us with any information that assist any recovery actions. This is a standard practice in the insurance market and contributions made from other insurance cover serve to keep the costs of your premiums down. The information provided should not affect your renewal premiums or no claims discount.

Please answer the following questions and provide details as required. For questions that require a YES / NO response, please tick the appropriate boxes. Failure to do so may delay your claim.

1. Do you have a bank account?	Yes ☐	No ☐

A bank account you hold may offer Travel Insurance cover as part of the benefits. Under no circumstances will your bank account information be used other than to obtain a contribution from the Travel Insurance provider. This will not affect your bank account in any way.

	Name of bank (e.g. HSBC)	Type of account	Account holder name	Account number

2. Was a credit card or debit card used to pay all or part of the trip cost? (Certain credit or debit cards provide an element of travel cover)	Yes ☐	No ☐

	Card issuer	Type of card e.g. Visa	Cardholder name	Card number

3. Do you have a Household Contents insurance policy? (Some household contents policies provide an element of travel cover)	Yes ☐	No ☐

	Name of Insurer		Policyholder name	Policy number

4. Do you hold any Private Medical Insurance?	Yes ☐	No ☐

	Name of Insurer		Policyholder name	Policy number

5. Do you consider anyone to blame for the incident?	Yes ☐	No ☐

If yes, please provide details.

It is a condition of the policy and your responsibility to provide sufficient documentation to support your loss. Failure to provide the required documentation, including the details of any other insurances, will delay and may invalidate the claim.

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Access to Medical Reports 1988

It may be necessary to apply for a medical report from a Doctor who has cared for you, and we ask that you give your consent by signing the claim form declaration. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988, and the procedures for dealing with the reports. You do not have to give your consent, but if you do, you can say whether you wish to see the report (or have a copy of it) before it is sent to us. If you say you wish to see the report, we must tell you at the same time as we write to the Doctor and we must tell him / her you wish to see the report. You have 21 days to contact the Doctor about arrangements for you to see the report.

Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied (if you ask). If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his / her costs.

Once you have seen a report, before it is sent to us, the Doctor cannot submit it until he has your written consent. You can write to the Doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your view on any part which he will not amend.

The Doctor is not obliged to let you see any part of a report if, in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctors intentions towards you or if disclosure would likely to reveal information about you or the identity of another person who has supplied information about you, unless that person has consented to the information relates to, or has been supplied by a health professional involvement in caring for you. In such cases, the Doctor must notify you in writing and you will be limited to seeing any remaining part of the report. If it is the whole of the report that is affected, he / she must not send it to us unless you give your written consent.

Preliminary Medical Certificate

To be completed by the usual medical practitioner of the ill / injured person. Please continue on a separate sheet of paper if necessary.

This information will be treated as PRIVATE AND CONFIDENTIAL. PLEASE COMPLETE IN BLOCK CAPITALS.

1. Patient name	
2. Patient age	
3. Are you the patient's usual Medical Practitioner?	
4. If so, for how long?	
5. a. State the date you first attended the patient for the present illness / injury. b. If for pregnancy reasons, give date confirmed & expected date of delivery.	
6. Please give a brief account, with dates of onset, course and progress of present illness / injury.	
7. Has the Patient received a terminal prognosis?	
8. a. Please provide dates and details of any in-patient treatment. b. Date placed on waiting list	
9. Has the patient suffered from the same or similar condition in the past? If the answer to this is YES, is the present illness, in your opinion, resulted in any way from the past condition?	
10. Has the patient been totally disabled from attending to any aspect of his / her business of occupation as a result of this condition?	
11. When did total disability cease? If continuing, when do you anticipate return to work?	
DOCTORS DECLARATION: I declare that I have examined the patient named above and / or have referred to their medical records and confirm that the information given above is a true and accurate statement, and further that no material information has been withheld.	This section to be validated by surgery's stamp

Print name		Signed	Date

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Claimants declaration and signature

1. I declare that all details and particulars given in respect of the claim（s）made herein constitute a true and accurate statement.
2. To the best of my knowledge and belief I have not omitted any material information which would affect the insurers assessment of this claim.
3. I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that ERV will not accept any liability if any payments are not distributed proportionately to the persons concerned.
4. I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to ERV. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act（AMRA）or other similar legislation.
5. I am aware that an insurance claim made in the knowledge that any element thereof is fraudulent is a criminal offence and that this will invalidate the policy and will render me liable to prosecution.
6. I consent to ERV :
   a. recording, storing and using my personal data in an electronic record of this claim ; and
   b. sharing the record of this claim, including my personal data, with other insurers and interested parties as part of insurance industry anti-fraud initiatives ;

   in accordance with the General Data Protection Regulation.

I have read and understand the declaration above and included the necessary documents to substantiate my claim.

Claimant（s）full name（s）

Client ' s signature

Date D D M M Y Y Y Y

Full name of an authorised representative of the corporate policy holder（corporate and / or education group cover）

Signature of authorised representative

Date D D M M Y Y Y Y

I / We authorise ____ to act on my behalf in this matter.

Client ' s signature

Date D D M M Y Y Y Y

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Confidentiality and data protection

Consent

When you bought your policy you gave explicit consent for your personal data, and that of others insured under your policy, to be collected and processed by us in accordance with this Data Protection Notice.

When you make a claim you may also provide us with personal information about you, other insured persons and others on whom your trip and claim might depend. When providing us with Personal Information about another individual, you confirm that you are authorised by them to provide it for use as described below.

How we use your personal data

We use your personal data for the purposes of providing you with insurance, handling claims and providing other services under your policy and any other related purposes（this may include underwriting decisions made via automated means）. We also use your personal data to offer renewal of your policy, research or statistical purposes and to provide you with information, products or services that you request from us or which we feel may interest you. We will also use your personal data to safeguard against fraud and money laundering and to meet our general legal or regulatory obligations.

We collect and process your personal data in line with the General Data Protection Regulations and all other applicable data protection legislation. The Data Controller of the arrangement and processing of this policy and the handling of claims under it, is ERV.

Special categories of personal data

Some of the personal data you provide to us may be more sensitive in nature and is treated as a Special Category of personal data. This could be information relating to health or criminal convictions, and may be required by us for the specific purposes of underwriting or as part of the claims handling process. The provision of such data is conditional for us to be able to provide insurance or manage a claim. Such data will only be used for the specific purposes as set out in this notice.

Sharing your personal data

We will keep any information you have provided to us confidential. However, you agree that we may share this information with other companies within the ERV Group and with third parties who perform services on our behalf in administering your policy, handling claims and in providing other services under your policy. Please see our Privacy Statement for more details about how we will use your information.

We will also share your information if we are required to do so by law, if we are authorised to do so by you, where we need to share this information to prevent fraud.

We may transfer your personal data outside of the European Union（EU）. Where we transfer your personal data outside of the EU, we will ensure that it is treated securely and in accordance with all applicable data protection legislation.

Your rights

You have the right to ask us not to process your personal data for marketing purposes, to see a copy of the personal information we hold about you, to have your personal data deleted（subject to certain exemptions）, to have any inaccurate or misleading data corrected or deleted, to ask us to provide a copy of your personal data to any controller and to lodge a complaint with the local data protection authority.

The above rights apply whether we hold your personal data on paper or in electronic form.

Your personal data will not be kept for longer than is necessary. In most cases this will be for a period of seven years following the expiry of the insurance contract, or our business relationship with you, unless we are required to retain the data for a longer period due to business, legal or regulatory requirements.

Further information

Any queries relating to how we process your personal data or requests relating to your personal data rights should be directed to :

Data Protection Officer, ERV, Afon House, Worthing Road, Horsham, RH12 1TL, United Kingdom

Email : Dataprotectionofficer@erv.co.uk

Phone : +44（0）1403 788 510

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Settlement by BACS

For your convenience and to offer an efficient smoother service, we would like to pay any claim settlement due directly into your bank account. Please provide ALL your details on this form as requested below, remembering to sign and date also.

If you do not wish to provide your bank details, any settlement due on your claim will be issued by cheque and may take a little longer to process.

You will receive an email from us to confirm when this payment has been made.

Your details	
Name of Claimant	
Email Address Where we will send confirmation of payment	

Bank account details	
Name of Payee This should be the same as held on the bank account	
Bank Name	
Bank Address inc. Country and Postcode	
Bank Account Number	
Sort Code	

If your bank account is held abroad, please also enter the following details :	
IBAN / BIC number	
Swift Code	

Signed

Date D D M M Y Y Y Y

IMPORTANT : We do not accept liability for any errors due to the incorrect bank details being provided by you.

PLEASE CHECK ALL DETAILS PRIOR TO SUBMITTING YOUR CLAIM.