

# STUART ALEXANDER LTD

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## Cancellation/Loss of Deposit Claim Form

### SECTION 1 (Claimant details)

TITLE	FULL NAME	OCCUPATION	DATE OF BIRTH
1			
2			
3			
4			
5			

Address	
	Post Code
Daytime Tel No	Country of Residence
Travel/Tour Operator	Country of Destination
Departure Date	Return Date
Date insurance was purchased	

### SECTION 2 (Claim details)

CANCELLATION/LOSS OF DEPOSIT	
Reason for cancellation	
If the cancellation has been caused by a person not travelling and not insured on your policy, please state relationship of that person to you	
Booking Date	Date Cancelled
Total Amount of Deposit Paid	Date Paid
Total Amount of Balance Paid	Date Paid
Amount Refunded	Date Refunded
Total Amount Claimed £	
<b>If the cancellation is for medical reasons the Medical Certificate, on the next page of this form, MUST be completed by the usual Doctor for the person whose condition caused cancellation of the trip. Please also ensure that the GP, when completing the Medical Certificate, is aware of the date insurance cover was purchased, as stated in Section 1.</b>	

## MEDICAL CERTIFICATE

<b>To be completed by the regular medical attendant of the person whose injury/illness give rise to the claim.</b>	
This certificate is to be completed at the claimant's own expense and is not refundable by Insurers	
1. Full Name of Patient	
2. Age	
3. Are you the regular medical attendant? If so, for how long? If not, what is your involvement with this matter?	<b>Yes/No</b>
4. State precise nature of: Medical condition/illness/injury/cause of death If injury, state how this was caused	
5. a) State exact date of onset as in 4 b) Date first consulted c) Date when there was any deterioration, if applicable	a) b) c)
6. Was patient waitlisted for hospital admission If yes, state a) Date waitlisted b) Date	<b>Yes/No</b> a) b)
7. Please give details of any previous medical history which has a bearing on the condition in 4 above	
8. Please state whether, at the time that the balance of the holiday cost became due, the patient was, in your opinion: a) Fit to Travel b) Undergoing medical treatment If yes to b), what was the treatment given and was it reasonable for the patient to continue with the travel plans?	<b>Yes/No</b> <b>Yes/No</b>
9. Please provide details of the state of patient's health at the time the Insurance was effected (refer to Section 1)	
10. If cancellation is as a result of pregnancy, what is EDD and reason for cancellation advice?	
11. Please advise the date when it first became apparent that the holiday should be cancelled	
12. Please state the exact date you advised the need to cancel	
13. Are you prepared to certify that solely due to the condition described in 4 above, the claimants are compelled to cancel the holiday arrangements?	
<i>I certify that the information given is correct</i>	
<b>Name (please print)</b>	<b>Qualifications</b>
<b>Signature</b>	<b>Date</b>
<b>Address</b>	

**TO BE COMPLETED BY THE CLAIMANT**

I hereby authorise the above-named Doctor and/or his practice to release any information required by Insurers and/or their appointed Loss Adjusters to deal with any claim

<b>Name</b>	<b>Signature</b>	<b>Date</b>
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**DECLARATION (to be completed by all claimants)**

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I/We declare that all the information supplied is true and correct in every aspect and that no relevant information has been withheld. On settlement, I/We transfer any rights of subrogation, salvage, and recovery to the Insurers and/or their Loss Adjuster.

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**Signed** \_\_\_\_\_ **Date** \_\_\_\_\_

**DOCUMENTS REQUIRED TO SUPPORT YOUR CLAIM**

***IMPORTANT: ORIGINAL DOCUMENTS ARE REQUIRED. WE DO NOT NORMALLY ACCEPT PHOTOCOPIES OR FAXED DOCUMENTS***

1. The tour operator's booking invoice plus cancellation invoice showing charges incurred.
2. Proof of cancellation, e.g.
  - a) Medical – Medical Certificate included in Claim Form to be completed.
  - b) Death – Death Certificate. Also the medical Certificate in Claim Form to be completed.
  - c) Redundancy – letter from employer confirming date you first were aware of being made redundant and length of service.
  - d) Attendance at court – the court subpoena