EXTRAMILE TRAVEL SCHEME
TRAVEL – (Section 5) CLAIM FORM

Claim Number: A claim number will be allocated once this form is returned

IN FIRST INSTANCE PLEASE EMAIL THIS CLAIM FORM AND SUPPORTING EVIDENCE TO claims@extramileinsurance.co.uk

We may request Hard Copies of all receipts and correspondence in relation to your claim please use the address to the right quoting your Claim Reference Number We aim to process the initial information in five working days

AICUK Ltd
Office 1&2,
203 &205 The Vale
London
W3 7QS

This claim form is being provided to you as requested in order that you can make a claim for under Section 5 subject to the terms and conditions of your travel insurance policy. Please keep a copy of this claim form and other documents for your own records

If the claim relates to tragic circumstances such as a death, please accept our sincere condolences. In this event the name and address of the **CLAIMANT** *(please see question Q01 below)* should relate to the person with whom we should correspond. We regret that it is essential for a death certificate to be provided in these circumstances.

IMPORTANT DOCUMENT CHECK LIST – Please use and complete incomplete information will cause delays We require scanned copies of all supporting evidence to be submitted with the Claim form initially by email to the email address above. We may ask for hard copies of the form and all documentation to be sent by post to our address above			**PLEASE TICK**			
			Enclosed	**Previously Sent**	**Not Available**	**Not Applicable**
ALL CLAIMS	**CERTIFICATE OF INSURANCE**	(or other proof of payment of insurance premium i.e. the Tour Operators booking invoice)				
ALL CLAIMS	**HOLIDAY BOOKING INVOICE**	as issued by the booking Agent & Tour Operator (if applicable)				
CANCELLATION	**TOUR OPERATORS CANCELLATION INVOICE**	To support details of cancellation				
CANCELLATION	**CONFIRMATION OF PAID / REFUND AMOUNT**	To support details of cancellation				
CANCELLATION CURTAILMENT	**MEDICAL CERTIFICATE**	to support details of illness or injury				
CANCELLATION CURTAILMENT	**CONSENT TO OBTAIN MEDICAL REPORT**	To support details of cancellation and curtailment				
CANCELLATION	**DOCUMENTARY EVIDENCE TO SUPPORT NON MEDICAL CANCELLATION / DELAY CLAIM**	To support details of cancellation				
CURTAILMENT	**DOCUMENTARY EVIDENCE OF RETURN HOME EARLY**	To support details of curtailment				
CANCELLATION CURTAILMENT	**DEATH CERTIFICATE**	(if applicable) to support details of cancellation and curtailment				
CURTAILMENT MISSED DEPARTURE	**ORIGINAL TRAVEL TICKETS INC ANY UNUSED ITEMS**	(i.e. flight coupons/ferry tickets)				
CURTAILMENT MISSED DEPARTURE	**ADDITIONAL TRAVEL TICKETS**	(if applicable)				
HOSPITAL BENEFIT	**EVIDENCE OF HOSPITAL ADMISSION AND DISCHARGE**	(only applicable if the Claimant was an in-patient in hospital)				
MISSED DEPARTURE	**A REPORT FROM AA/RAC/MOTORING ORGANISATION/GARAGE ETC**	Confirming date time and circumstances				
MISSED DEPARTURE	**LETTER FROM PUBLIC TRANSPORT COMPANY**	Confirming date time and circumstances				
DELAYED & LOST/DAMAGED BAGGAGE	**BAGGAGE CHECKS ALONG WITH TRAVEL TICKETS**	To confirm delayed lost/damaged baggage				
DELAYED & LOST/DAMAGED BAGGAGE	**AIRLINE CARRIERS OFFICIAL REPORT**	To confirm delayed lost/damaged baggage				
DELAYED BAGGAGE	**PROOF OF DATE AND OR TIME BAGGAGE WAS RETURNED TO YOU**	To confirm delayed baggage				
DELAYED & LOST/DAMAGED BAGGAGE	**RECIEPTS FOR THE ITEMS BEING CLAIMED FOR OR OTHER EVIDENCE OF PURCHASE**	To confirm delayed lost/damaged baggage				
ALL	**ANY OTHER DOCUMENTARY EVIDENCE TO SUPPORT YOUR CLAIM**					

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CLAIMANT DETAILS	
Q01.	Title: First Names: Surname:
Q02.	Date of Birth: / / Present Age:
Q03.	Occupation:
Q04.	Address:
	Post Code:
Q05.	Home Tel: Mob Tel: Work Tel:
	E-mail:

TRIP & INSURANCE DETAILS	
Q06.	Trip booking date: / / Period from: / / to: / / Number of days:
Q07.	Number of people in your party:
Q08.	Trip Country & Destination:
Q09.	Purpose of Trip (Business Travel. Holiday, Student studying abroad etc)
Q10.	If the trip was for Business please describe work being undertaken during the trip
Q11.	Name of the travel / booking agent who issued the policy:
Q12.	Travel Insurance Policy Number (as shown on your Insurance Confirmation Letter):
Q13.	Policy issue Date as found on your Insurance Confirmation Letter ***(very important)***: / /
Q14.	Method of payment for the trip (Delete as necessary): Credit Card / Debit Card / Cheque / Cash/ Other
	If credit / debit card was used please provide details: Card Issuing Company:

CANCELLATION CLAIM DETAILS – ***WHERE A MEDICAL CERTIFICATE IS REQUIRED THIS IS FOUND AT THE END OF THIS CLAIM FORM***

Q15. Kindly list all persons cancelling the trip that are insured by this policy and if due to medical reasons give their relationship to the person named on the medical certificate (list on additional sheet if necessary)

Insured Name	Age	Relationship to Patient

Q15. Cancellation date:
a. Verbally (if applicable) Date: / / b. In Writing Date: / /

Q16. If the cancellation was due to medical reasons or death, please give details below and ***arrange for the medical certificate on page 3 of this form to be completed*** by the normal General Practitioner of the person whose medical condition has caused the cancellation of the holiday/trip.
Medical Reasons:

Q17. Was the person named in the Medical Certificate on page 3 due to travel on this trip (Delete as necessary)? **YES / NO**

Q18. If the cancellation was for non-medical reasons covered by the policy please provide documentary evidence to support the claim (it may be necessary to correspond further) Non-medical Reasons:

Q19. Please detail below the amount of the claim

INDEPENDENT ARRANGEMENTS	£	PACKAGE TRIPS ONLY	£
Cost of Tickets		Total cost of holiday	
Cost of accommodation		Deduct insurance premiums	
Deduct refunds received or advised		Deduct refunds received or advised	
Final amount claimed before excess		**Final amount claimed before excess**	

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CURTAILMENT CLAIM DETAILS - *WHERE A MEDICAL CERTIFICATE IS REQUIRED THIS IS FOUND AT THE END OF THIS CLAIM FORM*

Q19. Kindly list all persons curtailing the trip that are insured by this policy (list on additional sheet if necessary)

Insured Name	Age	Relationship to Patient

Q20. The date the holiday was curtailed: Date: / / **Q15.** Number of Nights Lost:

Q21. Please advise the reason for the curtailment of the trip - **please give details below and *provide the information as detailed in the DOCUMENT CHECK LIST on page 1 of this form*** Reason:

Q22. If the curtailment was due to a medical condition of a member of the travelling party have you also made a MEDICAL claim? **YES / NO**

Q23. Were the Assistance Company contacted **YES / NO** If 'YES' please provide name of company:
Assistance Company Ref No (if known): What type of assistance did they provide?

Q24. Complete the table below with details of the amounts you are claiming for:

Refund of Holiday/Trip Please note that Curtailment is calculated on a pro-rata basis			Details Of Any Other Expenses Incurred (continue on separate sheet if necessary)		
Total Cost of Holiday/Trip (excluding Insurance Premiums and Surcharges)	**Number of Nights Lost**	**Amount Claimed**	**Nature of Expense**	**Amount Claimed**	
Final Pro-rata Amount Claimed			**Total Additional Expenses Claimed**		

MISSED DEPARTURE - CLAIM DETAILS

Q25. Method of travel to departure point (delete as necessary): **PERSONAL CAR / TAXI / BUS / TRAIN / OTHER (describe):**

Q26. Expected Journey time to departure point: Hours Minutes **Q15.** Actual Journey time to departure point: Hours Minutes

Q27. Date, Time & Place of incident causing the missed departure**:** Date: / / Time : am/pm Place:

Q28. Date, Time & Place from which you were scheduled to depart: Date: / / Time : am/pm Place:

Q29. Date, Time & Place from which you eventually departed: Date: / / Time : am/pm Place:

Q30. Circumstances giving rise to your missed departure:

Q31. What efforts were made (if any) to reach your departure point on time:

Q32. If you missed your departure due to an accident or fault of a Third Party please confirm;
a. Name & Address of Third Party
b. Their Insurers in known Claim Number:

Q33. Complete the table below with the amounts you are claiming for

Insured Name	Amount Claimed £

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PERSONAL LIABILITY	
Q34.	Should you be contacted by any third party or agency alleging you were responsible for an accident or incident : 1. **You must not make any admission of liability whatsoever, or make any arrangements, offer, promise or payment without the Insurers written consent.** 2. Provide a written statement describing the alleged incident immediately by email to claims@extramileinsurance.co.uk to include: a. Date & Time of the alleged incident b. Details of the incident itself c. Parties involved – if known d. Witnesses e. Details of any authority involved (Police etc) 3. You must in first instance send a scanned copy of any correspondence unanswered via the email address above then to the address shown at the top of this form marked 'Extramile Insurance – Claims Department' some documentation can be time sensitive and failure to comply with this will prejudice your rights under this policy. 4. We may need additional information / interviews

HOSPITAL BENEFIT
This is dealt with under the Medical and Other Expenses Claim form – please complete that if you have not already done so

BAGGAGE (DELAYED)- CLAIM DETAILS	
Q35.	The date, time and place you should have received your baggage: Date: / / Time: : am/pm Place:
Q36.	The date, time and place you eventually received your baggage:: : Date: / / Time: : am/pm Place:
Q37.	The full details of how the incident occurred and what action was taken by you (please continue on a separate sheet if necessary)
BAGGAGE (OTHER LOSS) & MONEY- CLAIM DETAILS	
Q38.	The date, time and place of your or damage: Date: / / Time: : am/pm Place:
Q39.	The full details of how the incident occurred and what action was taken by you (please continue on a separate sheet if necessary)
Q40.	Was the incident reported to the airline/coach or shipping company **YES / NO** (if **YES** please enclose their original report): Date report made / / Time: : am/pm To whom was it reported:
Q41.	Was the incident reported to the Hotel /Travel/Holiday Representative **YES / NO** (if **YES** please enclose their original report): Date report made / / Time: : am/pm To whom was it reported:
Q42.	Was the incident reported to the Police or other relevant authority **YES / NO** (if **YES** please enclose their original report): Date report made / / Time: : am/pm To whom was it reported:
Q43.	Did you receive a delayed baggage payment at the time YES / NO If 'YES' from whom and amount £
Q44.	Name and addresses of any witnesses to the incident
Q45.	What items are you claiming for? **Please complete the CLAIM SCHEDULE overleaf**

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BAGGAGE & PERSONAL EFFECT ONLY								
(a) Initials of Owner	**(b)** Description of item and if damaged, type of damage	**(c)** Place of purchase (give name and location of shop and country if not UK or details of donor if presented as a gift)	**(d)** Date of purchase or approximate age	**(e)** Method of purchase Cash = csh Credit Card = cc Debit Card = dc Cheque = chq	**(f)** Original Cost	**(g)** Present Day Value (allowing for use, wear and tear)	**(h)** Amount Claimed	**FOR INSURER USE ONLY**

MONEY CLAIMS					
(a) Initials of Owner	**(b)** Type of Currency	**(c)** Amount of Currency	**(d)** Where Obtained	**(e)** Date Obtained	**(f)** Amount Claimed

MEDICAL CERTIFICATES – IMPORTANT

The following 'Access to Medical Reports Act 1988' relates to customers based in the United Kingdom however if on receipt of that Medical Certificate it is deemed necessary to obtain a further medical report from the doctor concerned in relation to this claim we will obtain further information from the doctor ourselves. In that event, before we write to the doctor we will request consent from the patient or next of kin as appropriate. If however you withhold your permission we will be unable to proceed with your claim until the further information required is supplied.

ACCESS TO MEDICAL REPORTS ACT 1988 - UK Customers only

Where a Medical Certificate is requested as part of the evidence for your claim You are responsible for arranging its completion However, if on receipt of that Medical Certificate it is deemed necessary to obtain a further medical report from the doctor concerned in relation to this claim we will obtain further information from the doctor ourselves. In that event, before we can write to the doctor we require consent from the patient or next of kin as appropriate. Before signing the consent form, the patient concerned should read the following summary of their rights under the Access to Medical Reports Act 1988;

a) You can withhold your permission but if you do we will be unable to proceed with your claim if further information is required
b) If you wish to see the medical report, you must indicate on the claim form and contact your doctor within 21 days about arrangements to see the report. Whether or not you wish to see the report before it is sent to us, the doctor must let you see a copy for up to 6 months after it is supplied, if you ask
c) You can ask the doctor if he/she will amend any part of the report, which you consider to be incorrect or misleading. If the doctor is not in agreement you may append your comments

Your doctor can in certain circumstances withhold the report from you, or any part of it.

CONSENT TO OBTAIN A MEDICAL REPORT TO BE COMPLETED BY THE PATIENT OR NEXT OF KIN (AS APPROPRIATE)

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

I have been informed of my Statutory Rights under the Access to Medical Reports Act 1988 (per the Claim Guidance Notes) and consent to Claims Settlement Agencies Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. In that event I do/do not wish to see (or have a copy of) the medical report before it is sent to Claims Settlement Agencies Limited.

Patient Name: Signed (Patient): Date: / /

Doctor's Name: Address:

MEDICAL CERTIFICATE

TO BE COMPLETED BY THE PATIENT'S GENERAL PRACTITIONER AT THE EXPENSE OF THE CLAIMANT

Note: The patient is the person whose medical condition has caused the cancellation of the holiday/trip and does not have to be a member of the travelling party. To avoid delays please complete this certificate in FULL and in BLOCK CAPITALS and answer each question as fully as possible. Thank you for your co-operation.

01. Name of the patient: Date of birth: / /

02. Relationship to claimant named in question Q01 on page 1 of the claim form (if not the claimant):

03. Please state the nature of the illness/injury that makes cancellation of the trip medically necessary and prevents travel:

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

Date: / / Time: am/pm

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05. Is there a previous history of the above condition or other relevant conditions? **YES / NO** If YES then please advise;

a. details: _____

b. date of onset: Date: ____ / ____ / _____ Diagnosis Date (if different): Date: ____ / ____ / _____

c. has the patient been under regular medical review for the condition(s) **YES / NO** If YES since when? Date: ____ / ____ / _____

d. is the patient on regular medication for the condition(s) **YES / NO** If YES date first prescribed: Date: ____ / ____ / _____

06. At the date the policy was effected (please refer to question **Q11.** overleaf for the date) or at any time during the 12 months prior to that date was the patient;

a. receiving in-patient treatment **YES / NO** If YES please give date: ____ / ____ / _____

b. on a waiting list for treatment **YES / NO** If YES please give date: ____ / ____ / _____

c. aware of a Terminal Prognosis **YES / NO** If YES please give date: ____ / ____ / _____

07. At the date the policy was effected (same date applies as per Q06 above) was the patient;

□ Fit to travel □ Not Fit to travel □ Doubtful □ Not applicable as the Patient was not a member of the travelling party

08. If relevant to the condition has the patient suffered from any previously diagnosed psychiatric disorder **YES / NO**. If YES please give the cause of such condition:

09. What date did you advise the cancellation of the holiday necessary. Date: / /

10. If the cancellation is due to pregnancy please give;

a. Date of confinement: ____ / ____ / _____

b. Date pregnancy confirmed: ____ / ____ / _____

c. Date of LMP: ____ / ____ / _____

d. What illness/condition connected with the pregnancy gave rise to your recommendation not to travel?

11. Were you aware of the holiday plans when you were first consulted YES/ NO If No please confirm the date cancellation could reasonably have been anticipated: / /

12. If the patient was not travelling, could the travelling person(s) have foreseen or anticipated any possibility that the medical condition or related condition could have caused the cancellation of the trip either;

a. At the date the holiday was booked (see and insert date from question **Q06** on page 2 for date) / / **YES / NO**

b. At the date the insurance was taken out (see and insert date from question **Q11** on page 2 for date) / / **YES / NO**

If unsure, please give further details:

13. Can you certify the sole reason for cancellation was due only to the condition stated in question 03 above? **YES / NO**

Signature:

Qualifications:

Date: / /

Name & Address

Validation Stamp

EXTRAMILE TRAVEL SCHEME TRAVEL – (Section 5) CLAIM FORM	**Claim Number:** A claim number will be allocated once this form is returned

POLICY EXCESS - IMPORTANT!

The Policy Excess is the amount deductible from each and every claim.

If you require us to pay any bills direct, please confirm below whether the Policy Excess was paid and submit a receipt to show the payment.

If you did not pay the Policy Excess to the Doctor/Hospital at the time of treatment then please remit a cheque payable to ASUA Ltd* for the appropriate sum *(please refer to your Policy Conditions for details of the amount)*.

*ASUA Ltd are the Extramile Insurance Scheme Administrators and hold Premium on behalf of Almaseer Insurance Company and Lloyds Underwriters, they are FCA regulated and come under the Financial Services Compensation Scheme (FSCS)

Excess Paid? YES / NO If 'YES' to whom (name of Doctor/Hospital):	
Currency Used:	**Amount Paid:**
Are further accounts to be submitted? YES / NO If 'YES' please provide details:	
To whom do you wish any personal payment to be made if different to the Claimant named in Q01?	**Name:**

DECLARATIONS TO BE COMPLETED IN ALL CIRCUMSTANCES

OTHER INSURANCES AND PREVIOUS CLAIMS

Q46.	Do you have any other insurance that covers the expenses you are claiming **YES / NO** If 'YES' please provide the full details of the policy holder (if different to claimant), Name of Policy Holder: The company name/address: The policy number:		
Q47.	Has this claim been submitted (or will it be) to the other insurer or to any other party? **YES / NO** Their ref (if known):		
Q48.	Have you or any other person named on this form ever made any previous claim for any of the sections being claimed against in this policy against this or any other Insurer: **YES / NO** *(Please continue on a separate sheet if necessary)*		
	1	a) Date: / / b) Incident: c) Amount claimed d) amount settled e) i) Insurer who claim was with ii) Adjuster who dealt with claim	
	2	a) Date: / / b) Incident: c) Amount claimed d) amount settled e) i) Insurer who claim was with ii) Adjuster who dealt with claim	

DATA PROTECTION NOTICE

AICUK Ltd may use your information together with other information for underwriting, statistical analysis and claims. We may disclose your information to our service providers, agents and business partners for these purposes. We may also share your information with other interested parties and outside agencies to check the details and prevent fraudulent claims. We may also disclose your information to our agents to investigate or prevent fraud.

DECLARATION – To Be Completed By The Claimant Aged Over 16 or the Next of Kin if Aged Under 16

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AICUK Ltd, agents and business partners may contact anyone who can give them information relevant to my claim. I confirm that the information that I have given is true and if any of the information given by me (or anyone on my behalf) is incorrect, I agree that such inaccuracy may cause me to forfeit my rights under the policy.

In the event of a Third Party being liable, on settlement of the claim I hereby subrogate my rights to the company to recover their costs.

Payments: Subject to admission of liability, we will make payment in favour of the claimant **(aged over 16)** as detailed in question 01 overleaf but if an alternative payee is required please state below.

I have read and fully understood the above declaration.

Name	Signature	Date of Birth	Date of Signature
		/ /	/ /
Relationship to Claimant (if different)			

Please ensure you have completed this form in its entirety and have used the check list to ensure all the relevant documentation has been scanned and is sent by email with this form. Where we request that we need a hard copy of any information sent to us electronically we will only accept original documentation not copies or duplicates.