

Sedgwick, Merrion Hall, Strand Road, Sandymount, Dublin 4, Ireland.

Email : travel@ie.sedgwick.com

Tel: 00353 (0) 1 6619 133 Fax: 00353 (0) 1 6615 249

Curtailment (Early Return Home) – Claim Form

Sedgwick Travel Claims are committed to providing a quality service. In order for us to assist you as quickly and efficiently as possible, it is important that you provide all necessary documentation.

Documentation Required :- Failure to provide can result in our being unable to process your claim

Please tick to confirm you have attached the following documents		[Tick]
Fully Completed Claim Form	Complete each section. Do not use N/A.	<input type="checkbox"/>
Confirmation of Insurance	Insurance/Validation Certificate. In the case of credit card Insurance policies, please forward your credit card statement showing payment of the trip / holiday. IMPORTANT: IF YOU ARE PROVIDING YOUR CREDIT CARD STATEMENT, PLEASE ENSURE ONLY THE FIRST 6 AND LAST 4 DIGITS OF YOUR CREDIT CARD NUMBER ARE SHOWN	<input type="checkbox"/>
Confirmation of original trip dates	Tour Operators Confirmation Booking invoice – this should also include a breakdown of travel and accommodation costs. Please forward original travel tickets you may have and any other documents issued as evidence of the trip.	<input type="checkbox"/>
Additional Expenses	Receipts for additional expenses incurred, along with any new flight tickets and confirmation flight booking.	<input type="checkbox"/>
Completed Medical Certificate (To be completed ONLY if the 24 hour Medical Assistance Company was not contacted or did not authorise the curtailment.)	The medical certificate enclosed must be completed by the usual medical practitioner of the person whose condition gave rise to the claim. This is also required in the event of death. If the assistance company was not contacted or did not authorise the curtailment, please provide written confirmation from the treating medical practitioner of the necessity to curtail the trip. Also provide a full written explanation as to why the assistance company was not contacted.	<input type="checkbox"/>
Death Certificate	Please forward death certificate if appropriate. Please note, the medical certificate will <u>also</u> have to be completed.	<input type="checkbox"/>
Any Additional Information/documentation	Any additional information or documents which you wish to enclose to substantiate your claim.	<input type="checkbox"/>

Curtailment (Early Return Home) – Claim Form Continued

Our aim is to process your claim as efficiently as possible. In order to achieve this please ensure that you fully complete the form and provide the original documents requested on the Information Sheet. **(We strongly recommend you retain copies). Please note – if the information requested is not supplied, this can hold up your claim, and we may not be able to process it.**

NB. All sections MUST be FULLY completed. (In BLOCK CAPITALS please)

Name of Policy Holder (include Mr/Mrs/Ms etc)	<input style="width: 95%;" type="text"/>	Age	<input style="width: 95%;" type="text"/>
Name of Person to whom any payment should be made payable to - If different from above	<input style="width: 95%;" type="text"/>	Address	<input style="width: 95%; height: 40px;" type="text"/>
What Insurance Company Did You Take your Travel Insurance Out With?	<input style="width: 95%;" type="text"/>		
What Is Your Policy Called / Credit Card Type?	<input style="width: 95%;" type="text"/>	Post Code (If Applicable)	<input style="width: 95%;" type="text"/>
Policy / Certificate Number If Credit Card Please write the Number (first 6 and last 4 digits only please)	<input style="width: 95%;" type="text"/>	E-Mail address	<input style="width: 95%;" type="text"/>
Policy Issue Date	<input style="width: 95%;" type="text"/>	Incident Date	<input style="width: 95%;" type="text"/>
Home Telephone Number	<input style="width: 95%;" type="text"/>	Mobile Telephone Number	<input style="width: 95%;" type="text"/>
Country of Destination	<input style="width: 95%;" type="text"/>	Travel Agent	<input style="width: 95%;" type="text"/>
Departure Date	<input style="width: 95%;" type="text"/>	Booking Date	<input style="width: 95%;" type="text"/>
Original Return Date	<input style="width: 95%;" type="text"/>	Actual Return Date	<input style="width: 95%;" type="text"/>
Tour Operator	<input style="width: 95%;" type="text"/>	Occupation	<input style="width: 95%;" type="text"/>

We use personal information which you supply to us for administration, claims management and other insurance purposes, as further described in our Privacy Policy, available here: <https://www.sedgwick.com/global-privacy-policy#european-economic-area-and-the-united-kingdom>

Claimants signature and declaration

- I declare to the best of my knowledge all particulars in this form are true and accurate, with no omissions of any material information which would affect the insurers assessment of this claim
- I give permission for any medical practitioner, Police or similar authority mentioned with respect to this claim to release information regarding my records.
- I am aware that it is a criminal offence to defraud or attempt to defraud an insurer and that by doing so I may be prosecuted. I am also aware that should any element of this claim be found to be fraudulent in any way, all elements of the claim will be denied.
- I grant Sedgwick and the Insurers they represent, full rights of subrogation in respect to any payments made on my behalf. I further agree to fully co-operate with such recovery efforts that Insurers deem necessary.
- In the event of a third party being liable for the loss / damage, all rights of recovery pass to Sedgwick Travel Claims on settlement of this claim.

Signed

Date

Curtailment (Early Return Home) – Claim Form Continued

Details of all people included in this claim

Forename	Surname	Age

Actual Date of early return _____

Please state briefly why the trip was cut short

Name and age of person who illness or injury gave rise to this claim _____, _____

Relationship of this person to the insured _____

Condition which resulted in the curtailment _____

Did you contact Medical Health Check to declare the details of the above condition when you purchased the insurance? If Yes, please advise reference number _____

Did you contact the 24 hour medical assistance company at the time of the incident? **YES / NO**
If Yes, please state their reference number and the advice they gave. Did they authorise the early return home?

If No, please advise why not. _____

Total amount paid for Trip (Travel & accommodation)	
Amount Refunded	
Number of full days unused	

In the table below, please detail all extra travel and accommodation expenses incurred which you are claiming.

Item Number	Date Expense Incurred	Description of expense (Include full details, i.e. full flight details 'from – to')	Name of Provider i.e. Hospital / Clinic / Airline etc.	Amount Claimed (include currency)	Receipts attached? YES / NO
1					
2					
3					
4					

Is this trip covered under any other insurance (including Private Health Insurance?) **YES / NO**
If Yes, please provide details, or write 'None' and sign. _____

Please remember to include all ORIGINAL documentation requested. (Please retain copies for your records).
Confirmation of Insurance, Booking invoice, Flight Tickets (Both original and new), Medical Certificate, receipts for all expenses.
 For curtailment due to non medical reasons, provide:-
Redundancy:- A redundancy notice showing that you have been made redundant under applicable legislation and the date you were made aware of redundancy
Burglary, fire, storm or flooding to your home:- a letter from the police confirming that the incident occurred
Jury Service:- Letter from the courts showing the date on which you were made aware that you must attend for jury service or as a witness in court.

Medical Certificate – Curtailment

To be completed if the 24 hour Medical Assistance Company was not contacted or did not authorise your curtailment

This section must be completed fully by the usual G.P. of the person whose death, injury or illness gave rise to the claim, whether travelling or not. This form is not valid unless it bears the relevant surgery / hospital stamp.

Any expenses for the completion of this form are at the insured's expense.

Please complete all sections fully using **BLOCK CAPITALS**.

Claimant – please complete questions 1, 2 & 3 prior to giving to the medical practitioner.

1. Patients Name _____ 2. Booking Date _____ 3. Date of issue of insurance _____

4. Age _____ 5. Are you the patients usual Doctor? **YES / NO** How long for _____

6. Details of the medical condition giving rise to the claim

Diagnosis / Condition _____ Date of Diagnosis _____

Date of first attendance for this condition _____ Was it medically necessary to curtail the trip **YES / NO**

If Yes, please advise why _____

7. Has your patient been referred to a consultant / specialist or hospital within :-

a. 24 months of the purchase of insurance or the booking of the trip **YES / NO**

b. 18 months of the purchase of insurance or the booking of the trip **YES / NO**

c. 12 months of the purchase of insurance or the booking of the trip **YES / NO**

If YES, please provide full details including dates, condition, prescribed medicines, any follow up action

8. Has your patient been placed on a waiting list, either for treatment or investigation within 12 months of the purchase of insurance or the booking of the trip? (See question 2). **YES / NO**

If YES, please provide full details including dates of referral & Procedure and condition.

9. Has your patient suffered from or received any form of medical advice, treatment, or medication within the past 18 months for :

Heart or circulatory related condition (e.g. hypertension, angina, stroke)

A lung or breathing related condition

Any form of cancer

If YES, please provide full details including dates, condition, prescribed medicines, any follow up action.

10. Has your client received a terminal prognosis from a medical practitioner? **YES / NO**

If YES, Date of prognosis _____ Date when condition or related condition first arose _____

11. If your patient is now deceased, was there any pre-existing condition that was a contributory factor to the cause of death?

YES / NO IF YES, please elaborate _____

12. If the claim concerns pregnancy, please state

a. Date pregnancy confirmed by Doctor _____

b. Expected or actual date of confinement _____

c. What condition associated with the pregnancy has led you to curtail your trip _____

d. Has your patient had any complications in a previous pregnancy **YES / NO**

ii. If YES, please elaborate

DECLARATION

I have examined the above and/or referred to the relevant medical records and declare the details are accurate and correct and that no material facts have been omitted.

OFFICIAL OFFICE STAMP

Signed _____ Print Name _____

Date _____