CANCELLATION CLAIM FORM

Please complete all relevant sections of this Claim Form and return to:
P J Hayman Claims Department, Stansted House, Rowlands Castle, Hampshire PO9 6DX
Email: **claims@pjhayman.com**

PJHayman

Claim Number | | | | | | | | | | (for office use only)

If you require a large print version, please call 02392 419 020.
Please use **BLOCK CAPITALS** when filling in your form. If there is insufficient space for your answers please use the Additional Information box on page 6.

Check List of Required Documents

Please send the following to support your claim.

If you do not enclose all the documentation we have listed any settlement of your claim will be delayed.

Tick ✓ against documentation enclosed.

- ☐ Insurance Schedule (if you have an Annual Insurance a copy would be sufficient).
- ☐ Medical Pre-screening Confirmation (if applicable).
- ☐ Holiday Booking Invoice showing the date the holiday/trip was booked, who was booked to travel, travel dates, destination, amounts paid and purchase of your travel insurance (if applicable).
- ☐ Holiday Cancellation Invoice showing the date that the holiday/trip was cancelled, who has cancelled, the cancellation fee and the amount of refund that you will be receiving (if any).
- ☐ The Medical Certificate (on page 5), completed by the usual treating GP of person causing the cancellation. Other documents, such as hospital letters or death certificates, may be considered, although if submitted instead of the GP completed medical certificate, it may be necessary to request additional information.

Please Note - scan & photocopies are acceptable, however, we do always encourage you to retain the original documentation in case we require any particular documents to be sent in for inspection or retention. Examples where this would be required are high value claims (for prevention of fraud) where we are required to retain originals for a certain period of time.

Claimant/Contact Details:

Claimant Name: | Claimant Age:

Name of Person handling the claim: (if different to above)

Address for Correspondence:

Postcode: | Tel No:

Email address:

Trip Details:

Outward Journey Date: D D M M Y Y | Return Journey Date: D D M M Y Y

Country: | Destination:

Insurance Policy Details:

Name of Travel Insurance:
(e.g. the name of your coach travel provider)

Travel Insurance Policy Number: | Date Insurance Purchased: D D M M Y Y

Medical Screening Reference:

Please enclose the Medical Screening Confirmation – if applicable

Other Insurance Policies:

Do you hold any other insurance policy that may cover your claim (e.g. BUPA, bank account or credit card) ? ☐ Yes ☐ No

If yes, please give details

Names of people claiming under this insurance:

1.	2.	3.
4.	5.	6.
7.	8.	9.

Details of amounts paid for the trip:

Deposit	**£** :	Date Paid D D M M Y Y
Balance	**£** :	Date Paid D D M M Y Y
Amount refunded by your tour operator, travel agent, etc	**£** :	Date Paid D D M M Y Y
Insurance premium paid (Note: this is not refundable)	**£** :	Date Paid D D M M Y Y
Total amount claimed (cancellation charge)	**£** :	

Cancellation Due To Medical Reasons:

Description of injury/illness causing Cancellation:

Name of Person causing the Cancellation:

Your relationship to them:

P J Hayman & Company Limited may need to contact the GP who has completed the medical certificate, should further clarification be required. Please confirm that this is in order by providing the patient's signature below.

Note: Fees charged may not be considered by the policy.

Signature Of Patient:

Cancellation Due To Other Reasons:

Please state reason:

- If cancellation is due to **redundancy** please provide us with a letter from your employer confirming that you qualify for statutory payment under the Employment Protection Act.
- If cancellation is due to your **Jury service** please provide us with your Jury Confirmation letter showing us when you were notified of the Jury service and the dates you are required to attend court.
- If cancellation is due to **any other reason**, we may request additional independent confirmation of the need to cancel.

Date you cancelled your holiday/trip: Date: D D M M Y Y

How did you advise cancellation? By Phone: ☐ In Writing: ☐ In Person: ☐

Data Protection Notice

Personal Information – means information that identifies and relates to you or other individuals (i.e. your dependants). By providing Personal Information to P J Hayman & Company Limited you give us permission for its use as described below.

Full details about our use of Personal Information can be found in our full Privacy Notice at: www.pjhayman.com/documents/PJH_Privacy_policy.pdf or you may request a copy using the contact details provided.

When providing **Personal Information** about another individual to us, you confirm that you are authorised to provide it for use as described below.

Types of Personal Information we may collect and why:

Depending on our relationship with you, **Personal Information** collected may include:

- identification and contact information,
- payment card and bank account,
- credit reference and scoring information,
- sensitive information about health or medical condition,
- and other **Personal Information** provided by you.

Personal Information may be used for the following purposes:

- Insurance administration, (communications, claims processing and payment)
- Decision-making on provision of insurance cover and payment plan eligibility,
- Assistance and advice on medical and travel matters,
- Management and audit of our business operations,
- Prevention, detection and investigation of crime, (fraud and money laundering)
- Establishment and defence of our legal rights,
- Legal and regulatory compliance, including compliance with laws outside your country of residence,
- Monitoring and recording of telephone calls for quality, training and security purposes.

Sharing of Personal Information:

Personal Information may be shared with our group companies, Brokers and other distribution parties, Insurers and Reinsurers, Credit Reference Agencies, healthcare professionals and other service providers. **Personal Information** may be shared with other third parties (including government authorities) if required by law. **Personal information** (including details of injuries) may be recorded on claims registers shared with other insurers. We are required to register all third party claims for compensation relating to bodily injury to workers' compensation boards. We may search these registers to detect and prevent fraud or to validate your claims history or that of any other person or property likely to be involved in the policy or claim.

Security and retention of Personal Information:

Appropriate legal and security measures are used to protect **Personal Information**. All third party service providers are also selected carefully and required to use appropriate protective measures. **Personal Information** will be retained for the period necessary to fulfil the purposes described above.

International transfer:

Due to the nature of our business, **Personal Information** may be transferred to parties located in other countries with different data protection laws than in your country of residence.

Data requests:

To request access or correct inaccurate **Personal Information**, or to request the deletion or suppression of **Personal Information**, or object to its use, please email: customerservices@pjhayman.com and mark for the attention of the Data Controller, or write to Data Controller, The Old Theatre, Stansted House, Rowlands Castle, Hampshire PO9 6DX.

DECLARATION

I declare that the whole of the statements made and any other supplementary statements forming part of this claim are true in every respect and understand that a false declaration may invalidate my claim and could result in prosecution. I give permission for my **Personal Information** to be used and shared in the ways described above. I confirm that I will not provide any **Personal Information** about another person without that person's permission.

Customer Declaration - to be completed by ALL persons claiming aged over 16

P J Hayman & Company Limited, agents and business partners may contact anyone who can give them information relevant to my claim.
I/ We confirm that the information that I/ we give is true and if any of the information given by me/ us (or anyone on my/ our behalf) is incorrect, I/ we agree that such inaccuracy may cause me/ us to forfeit my/ our 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 above but if an alternative payee is required please state below.
I/ We have read and fully understood the above declaration.

Insured Name	Signature	Date of Birth	Date of Signature

Access to Medical Reports Act 1988

You are responsible for arranging completion of the Medical Certificate on page 5 of the claim form. 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, or any part of it, from you.

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 P J Hayman & Company Limited obtaining a further medical report from a doctor who has cared for me should it be deemed necessary. I do/do not wish to see (or have a copy of) the medical report before it is sent to P J Hayman & Company Limited.

Patient Name:	Signature (Patient):	Date:

Doctor's Name:

Address:

Settlement Method - Claims are paid by Bank Transfer.

Please complete the below to prevent us asking for this at a later date:

Bank Name/Address

Name on Account

Sort Code

Account Number

Medical Certificate

Please use **BLOCK CAPITALS** when filling in this form. Other documents, such as hospital letters or death certificates, may be considered, although if submitted instead of the GP completed medical certificate, it may be necessary to request additional information. This certificate is to be completed by the usual treating GP of the person causing the cancellation or curtailment. If there is insufficient space for your answers please use the Additional Information box provided.

Note: any fee incurred to complete the Medical Certificate may not be considered by the policy.

Name of patient: Age: Date of Birth: D D M M Y Y

Are you the patient's usual GP: Yes No How long has the patient been with the practice: Years Months

Precise nature of illness/injury causing cancellation of the holiday/trip:

Are you prepared to certify that solely due to the condition described above, the claimant(s) are compelled to cancel? Yes No

Is the above condition directly or indirectly related to any known pre-existing condition? Yes No

If yes, please provide details of the condition:

Date illness / injury causing the claim: D D M M Y Y

Date & time you were first consulted: hrs D D M M Y Y

Date referred to a consultant (if applicable): D D M M Y Y

Date wait listed for operation (if applicable): D D M M Y Y

Date admitted to hospital (if applicable): D D M M Y Y

Date discharged from hospital (if applicable): D D M M Y Y

Claims due to pregnancy

Date confirmed: D D M M Y Y

Expected due date: D D M M Y Y

The reason why the pregnancy necessitates cancellation of the holiday/trip:

Date you advised the patient to cancel: D D M M Y Y

If you did not advise the patient to cancel, on what date did the cancellation become medically necessary? D D M M Y Y

If possible, please indicate when the patient would be fit to travel? D D M M Y Y

Has a terminal prognosis been made? Yes No If yes, when was the patient made aware of this? D D M M Y Y

In the last 12 months has the patient been fit and well enough to travel? Yes No

If no, please provide details:

Were you advised of the planned trip? Yes No

If yes, please provide date: D D M M Y Y

If advised, were there any circumstances which could have reasonably been anticipated to give rise to a claim? Yes No

If yes, please provide details:

Address Stamp	I have examined the patient and referred to their medical records and I declare that the information given is correct and that no details relevant to this case have been omitted.
	Name:
	Qualifications:
	Signature: Date:

Additional Information: