CHUBB

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Claim form - Travel

This document contains fillable form fields.
It is recommended you **download** the file to fill in your information.

Data protection

We use personal information which you supply to us [or, where applicable, to your insurance broker] for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: https://www2.chubb.com/uk-en/footer/privacy-policy.aspx or by searching 'Master Privacy Policy' on https://www2.chubb.com/uk-en/. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at dataprotectionoffice.europe@chubb.com.

Before completing this claim form you may prefer to submit your claim online, 24 hours a day, 7 days a week. It's easy to use and provides a contemporary claims experience for all customers www.chubbclaims.co.uk

Please write in black ink and use block capital letters.

- All relevant sections must be completed or marked 'not applicable'.
- Complete the checklist and ensure that you sign the declaration at the end of this form.

Name of Policyholder:

Certificate/Policy Number:

Insured details

Insured Person forename(s) (Mr/Mrs/Miss/Ms):

Insured Person surname:

Full address:

Daytime Telephone Number:

Evening Telephone Number:

Postcode:

Date of birth:

Email Address:

Claimant details

Full Name of Claimant	Date of Birth	Claimant's Address (if different to insured person)	Relationship to Insured Person

Travel details

Type of travel: ☐ Business ☐ Leisure

If you have answered Leisure, please select the type of policy you hold

☐ Annual – a personal travel insurance policy that provides cover for multiple holidays over a period of one year

☐ Backpacker – a personal travel insurance policy that provides cover for travelling and working abroad for a specified period of time

☐ Single – a personal travel insurance policy that provides cover for one holiday for a specified period of time

☐ Secondee – a business travel insurance policy that provides cover for holidays taken by an employee living and working abroad

Country of departure:

Country of destination:

Country & City of Incident/Loss:

Date journey was booked:

Method of transport (if loss occurred in transit):

Scheduled departure date:

Time:

Scheduled arrival date:

Time:

Scheduled return date:

Time:

Please select your claim type by ticking from the selections below

Medical Expenses	Travel Disruption	Personal Belongings
☐ Injury	☐ Cancelled trip	☐ Lost
☐ Illness	☐ Trip cut short/ missed activities	☐ Stolen
	☐ Missed departure/connection	☐ Damaged
	☐ Delay	☐ Delayed
Please go to **Section 1**	Please go to **Section 2**	Please go to **Section 3**

1. Medical Expenses

Please give date, time and place where injured or taken ill:

Date / time:

Place:

Please describe the illness suffered/injuries sustained and details of treatment:

Have you suffered from this injury/illness in the past?

☐ Yes ☐ No

If YES please provide the date you first suffered from this injury/illness

Did you have a valid EHIC card at the time of this incident?

☐ Yes ☐ No

If YES please provide card details

Did the incident result in hospitalisation?

☐ Yes ☐ No

If YES, what was the date and time that you were admitted and discharged:

Admitted:

Discharged:

Please provide the name and address of your usual General Practitioner

Please provide name and address of hospital and treating physician:

Please go to Section 4 Additional Information

2. Travel disruption

Actual Departure Date/Time:

Actual Return Date/Time:

If delayed, please state total delay time:

Hours

Please give the reason for cancellation/curtailment/delay of the journey:

What was the date of Cancellation/Curtailment/Delay:

If the cancellation/curtailment was due to illness or injury, please confirm: Did you or a family member suffer the injury/illness?

☐ Me ☐ Family Member

If family member, what is their relation to you?

Please describe the illness/injury in more detail:

Have you/family member suffered from this injury/illness in the past?

☐ Yes ☐ No

If YES please provide the date you/family member first suffered from this injury/illness

Doctor's statement

This section must be fully completed by your own doctor or doctor providing outpatient treatment - any fee for completion of this section is the responsibility of the Insured Person.

Nature of complaint preventing travel:

Date treatment first sought:

Was cancellation of the journey medically necessary?

☐ Yes ☐ No

Signed:

Validation stamp:

Date:

Please go to Section 4 Additional Information

3. Personal belongings

Please give date of the loss/damage/theft/delay:

Please give full details of the loss/damage/theft/delay

Please provide the name of the authorities that this incident was reported to, and any references e.g. police, airline, hotel etc.

If the loss, damage or delay was caused by an airline or carrier, please provide:

Name of airline/carrier:

Amount of compensation received:

Baggage delay only – please confirm:

Scheduled date and time of baggage arrival:

Actual date and time of baggage arrival:

Total delay time:

Hours

Please go to Section 4 Additional Information

4. Additional Information

Please list all expenses and/or items you wish to claim (please complete on an addition sheet if necessary)

Claimant Name	Nature of Expense/ item description	Date expense incurred/original purchase date	Amount Paid	Currency Paid	Amount Claimed

Total Amount Paid:

Total Amount Refunded/Compensated:

Amount to be Claimed:

Has a claim been made against any other policy for this loss? ☐ Yes ☐ No

Please provide details of any other insurance providing cover for this incident or loss. For example, through your bank account, credit card, household insurance, mobile phone/gadget insurance or private medical insurance:

Name of Insurer/ Company	Address/ Contact Details	Policyholder/ Account holder Name	Account Number/ Policy Number

Do you consider anyone to blame for this incident or loss? ☐ Yes ☐ No

If Yes, please provide details:

Name of Insurer/ Company/Individual	Address/ Contact Details	Any Reference Numbers

Please provide any additional relevant information about your claim:

Access to Medical Reports Act 1988

Before your doctor can give a medical report on this claim form which is a requirement of this claim, you must give your consent. Before giving your consent, you should be aware of your rights under the act which are summarised as follows:

1. You may withhold your consent.
2. You may see the report before it is sent to us within 21 days from the date of this report.
3. You may ask to see the report for up to six months after the report is completed.
4. You may ask the Doctor to amend any part of the report which you consider to be incorrect or misleading. If the Doctor does not agree with your request you may attach your comments to the report.

NB: The Doctor may withhold all or part of the report from you if he considers that you may be physically or mentally harmed by it'

Patient Declaration

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to Chubb seeking medical information from any Doctor who at any time has attended me concerning conditions which affect my physical or mental health.
2. ☐ I do wish to see the report before it is sent to Chubb
   ☐ I do not wish to see the report before it is sent to Chubb
3. I authorise such Doctor to disclose such information to Chubb.
4. I agree that a copy of this consent shall have the validity of the original.

Signed:

Date:

Payee's bank details

If we approve your claim, we can credit the money direct to your bank account. This method is quicker, safer and more reliable than payment by cheque. If you would like us to do this, please complete the following:

Bank Sort Code

Account Number

Name of Account Holder(s)

Declaration

I declare that all the information given is to the best of my knowledge and belief, full true and correct.

Signed:

Date:

Checklist

Please enclose supporting documents. See list of examples below:

Medical Expenses

- Medical invoices
- Medical confirmation of illness/injury

Travel Disruption

- Original travel documents
- Replacement travel documents
- Airline confirmation of reason for cancellation/curtailment/delay
- If cancelled for medical reason – proof of this e.g. medical certificate
- If any other reason for cancellation – confirmation from relevant body
- Original boarding pass
- New boarding pass

Personal Belongings

- Receipts for items claimed
- Receipt/invoice for replacement items **or**
- Replacement estimates
- Travel documents
- Police report
- Property Irregularity Report
- Other loss report
- Receipts /invoices for emergency items purchased (in the event of baggage delay)

Please return the completed claim form together with any enclosures to your Insurance Broker or Chubb and please ensure:

☐ You have completed all relevant questions on this claim form

☐ You have enclosed all requested original documents (we recommend you retain copies)

☐ You have signed this claim form

Thank you for fully completing this claim form and enclosing all supporting documentation.

Chubb. Insured.℠