CLAIM No: _____
(For Office Use Only)

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Internet Curtailment (Early Return Home) – Claim Form

OSG Travel Claims are committed to providing you with 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.

If a claim is received without the correct documentation or the claim form has not been fully completed, this can delay the processing of your claim.

IMPORTANT – Insurers require ORIGINAL documents. You must provide, at your own expense, any documents required to process your claim. **We strongly recommend that you keep copies of all documents forwarded to us.**

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	Please complete each section. Do not use N/A	
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.	
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.	
Additional Expenses	Receipts for additional expenses incurred, along with any new flight tickets and confirmation flight booking.	
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 on this form 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, stating why it was necessary to curtail the trip. Also, provide a full written explanation as to why the assistance company was not contacted.	
Death Certificate	Please forward a death certificate if appropriate. Please note that the medical certificate will also have to be completed.	
Any Additional information/documentation	Any additional information or documents which you wish to enclose in order to substantiate your claim.	

We understand that it can, at times, be a daunting prospect when making a claim. Please help us to help you by following these guidelines.

- **Always send original documentation (we recommend you retain copies).**
- **Make sure that the claim form is fully completed and that the information given is as clear as possible.**
- **Always provide the information requested above. If for some reason, the documentation is not available, please attach a letter advising why it has not been enclosed.**

Internet 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.**(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.

N.B. All sections must be FULLY completed. (In BLOCK CAPITALS please)

Name of Policy Holder (include Mr/Mrs/Ms. etc)		Age	
Name of Person, to whom any payment should be made payable to (if different from above)		Address	
What Insurance Company did you take out your travel insurance with?			
What Is Your Policy Called?		Post Code (if applicable)	
Policy / Certificate Number **(If credit card, please write full credit card number)**		Email address	
Policy Issue Date		Incident Date	
Home Telephone Number		Mobile Telephone Number	
Country of Destination		Travel Agent	
Departure Date		Booking Date	
Original Return Date		Actual Return Date	
Tour Operator		Occupation	

Data Protection

In order to administer your claim, the information provided in this form may be held on computer and/or in manual files for administration and risk assessment purposes. We may disclose your personal data to and may request information from, other insurance companies for underwriting, claims handling and fraud prevention purposes.
By returning this form, you consent to our processing your personal data for the above purposes.

Claimants signature and declaration

- I declare to the best of my knowledge that all particulars in this form are true and accurate, with no omissions of any material information that would affect the Insurer's 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 liable to prosecution. 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 OSG Business Solutions and the Insurers they represent, full rights of subrogation in respect of any payments made on my behalf. I further agree to fully co-operate with such recovery efforts that Insurers may deem necessary.
- In the event of a third party being liable for the loss / damage, all rights of recovery pass to OSG Travel Claims, on settlement of this claim.

Signed: Date:

Internet Curtailment (Early Return Home) – Claim Form (continued)

Details of all insured 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 that resulted in the curtailment: _____

Did you contact Medical Health Check to declare the details of the condition, when you purchased the insurance? **YES/NO**
If YES, please advise the Health Check 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 on page 1 of this form and summarised below.
(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 the following:
Redundancy: a redundancy notice showing that you have been made redundant under applicable legislation and the date you were made aware of the redundancy.
Burglary, fire, storm or flooding to your home: a letter from the Police confirming that the incident occurred
Jury Service: a letter from the Courts showing the date on which you were notified of your required attendance 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 or 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. Patient's Name: _____ 2. Booking Date: _____ 3. Date of issue of Insurance: _____

4. Age: _____ 5. Are you the patient's 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. Was your patient 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 and any follow-up action: _____

8. Was your patient 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)? YES/NO
   A lung or breathing related condition? YES/NO
   Any form of cancer? YES/NO

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

10. Has your Client received a terminal prognosis? **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: _____

13. If the claim concerns pregnancy, please state:
    a. Date when pregnancy was confirmed by Doctor: _____
    b. Expected or actual date of confinement: _____
    c. What condition associated with the pregnancy has led you to advising against travel?
    _____
    d. Has your Patient had any complications in a previous pregnancy? **YES / NO** Date: _____
    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: _____