

For Official Use Only

CLAIM FORM



The HERITAGE ALL INSURANCE COMPANY LIMITED

i. PERSONAL PROPERTY/MONEY AND DOCUMENTS CLAIMS SECTION

CLAIM REFERENCE:

Please complete this form and return it with relevant documentation to the address below.

Please do not hesitate to call if you have any queries.

A. PERSONAL DETAIL

FULL NAME (AS PER POLICY):.....

Date of Birth:.....

Occupation:.....

Telephone:.....

Hours of Contact: (at above number).....

B. INSURANCE DETAILS

Policy Name:.....

Date Trip Originally Booked:.....

Travel Dates From:..... To:.....

Name of Travel Agent, If any Name of Tour Operator if any:.....

Hotel Accommodation details Resort Country:.....

(including baggage delay)

Date of Loss/Damage:.....

Place of Loss/Damage:.....

Full Details/Circumstances:.....

Was the Loss /Damage Reported to the Police?: YES.....NO.....

If NO, please state reason:.....

Date of Loss /Damage Reported to the Airline?.....YES.....NO.....

If NO, please state reason:.....

Date of Loss /Damage Reported to the Tour Operator?YES.....NO.....

If NO, please state reason:.....

Is your property also covered under a Household Contents Insurance?

YES.....NO.....

If YES, please give details below:

C. PERSONAL PROPERTY, MONEY AND DOCUMENTS

FULL Details of Items Lost/Damaged	Date of Purchase	Shop and Town where purchased	Purchase Price	Amount Claimed	Evidence of Value	For Office Use Only

Please continue on a separate sheet if there is insufficient space. Please mark all documents with your claims reference

State to whom settlement should be paid:

State preferred currency if not US\$:.....

THE FOLLOWING ORIGINAL DOCUMENTS MUST BE SENT WITH YOUR CLAIM FORM FOR CLAIM PROCESSING

Item	Enclosed
1. Your original holiday/flight confirmation and/or receipt or deposit receipt	YES/NO
2. Your certificate of Insurance	YES/NO
3. Your travel tickets	YES/NO
4. Police, Airline or Tour Operator report	YES/NO
5. Evidence of Ownership such as original receipts, valuations, credit card receipts	YES/NO
6. Any other relevant documentation to support your claim	YES/NO

ii. CURTAILMENT/MISSED DEPARTURE TRAVEL DELAY/PERSONAL LIABILITY CLAIMS SECTION

CLAIM REFERENCE:

Please complete this form and return it with relevant documentation to the address address at end of this form.

Please do not hesitate to call if you have any queries.

CANCELLATION/LOSS OF DEPOSIT/CURTAILMENT

Reason for Cancellation or Curtailment

(1) For Cancellation/Loss of Deposit

Date Trip originally booked:.....

Total Cost of holiday:.....

Date Insurance purchased:.....

Amount Refunded:.....

Date Trip Cancelled:.....

Amount Claimed:.....

(2) For Curtailment of Trip

Date Trip originally booked:.....

Date of Incident causing Curtailment:.....

Date Insurance purchased:.....

Actual Return Date:.....

Original Transport Method(Air/Ferry/Coach etc)

Amounts claimed for Additional

Expenses:.....

IF THE REASON FOR THE CLAIMS IS MEDICAL, THE ATTACHED MEDICAL CERTIFICATE OVERLEAF MUST BE COMPLETE BY THE USUAL DOCTOR OF THE PERSON WHOSE CONDITION GIVES RISE TO THE CLAIM

D. MISSED DEPARTURE/TRAVEL DELAY

Reason for Delay or Missed Departure:

(1) For Missed Departure

Point of Departure:.....

Date and Time of Planned Departure:.....

Transport Used (Air/Coach/Ferry, etc.)

Method Employed to Rejoin Trip:.....

Amount Claimed:.....

(2) For Travel Delay

Scheduled Date and Time of

Departure:.....

Actual Date and Time of Departure:.....

Number of hours delay:.....

Flight/Ferry number:.....

Airline/Ferry Company:.....

E. PERSONAL LIABILITY

Address of holiday apartment/hotel:.....
 Date and Time of Incident:.....
 Full Details of Incident (continue on a separate sheet if necessary)

THE FOLLOWING ORIGINAL DOCUMENTS MUST BE SENT WITH YOUR CLAIM FORM FOR CLAIM PROCESSING

Item	Enclosed
1. Your original holiday/flight confirmation and/or receipt or deposit receipt	YES/NO
2. Your certificate of Insurance	YES/NO
3. Your travel tickets	YES/NO
4. Proof of cancellation, medical certificate redundancy notice, court summons, etc.	YES/NO
5. Receipts for additional travel and/or accommodations expenses (if applicable)	YES/NO
6. Confirmation of cause of claim from carrier, breakdown organization or garage, etc.	YES/NO
7. Confirmation from the carrier stating reason for delay including actual travel time	YES/NO
8. Any other documentation to support your claim	YES/NO

(iii) MEDICAL EXPENSES CLAIM SECTION

CLAIM REFERENCE:

Please complete this form and return it with all relevant documentation to the above address. Please do not hesitate to call if you have any queries.

F. MEDICAL AND EMERGENCY EXPENSES/HOSPITAL BENEFIT

Date of Injury/Onset of Illness:.....
 Place of Injury/Illness:.....
 Details of Injury/Illness:.....
 Circumstances of Accident (if applicable):.....
 Have you suffered from the same/similar condition before? YES/NO

If YES, please ask your usual doctor to complete the attached medical certificate.

PLEASE NOTE: Any charge made by a doctor for medical reports must be paid by the claimant

If hospitalized, please state dates, Admitted/Discharged

Were you in possession of a valid E111* form?
 YES/NO (*For travelers in the E.C. only)

If NO, please provide your National Insurance Number:.....

Please sign to give SAS authority to use your E111.
 Signature):.....

Date of Treatment	Expenses Claimed	Amount Claimed	For office Use Only
		Total Amount Claimed	

Please continue on a separate sheet if there is insufficient space. Please mark all documents with your claims reference.

State to whom the settlement should be paid
THE FOLLOWING DOCUMENTS MUST BE SENT WITH YOUR CLAIM FORM FOR CLAIM PROCESSING

Item	Enclosed
1. Your original holiday/flight confirmation and/or receipt or deposit receipt	YES/NO
2. Your certificate of insurance	YES/NO
3. Your travel tickets	YES/NO
4. Hospital, Doctor, Chemist, Dentist receipts for amounts claimed(Non-UK only)	YES/NO
5. Receipts for additional travel and/or accommodation expenses(if applicable)	YES/NO
6. Confirmation of In-patient treatment for hospital benefit claim	YES/NO
7. Any other relevant documentation to support your claim	YES/NO

DECLARATION

I declare that to the best of my knowledge all particulars contained in this form are true and correct.

Signed:.....Date:.....

The completed form should be returned to:-

THE HERITAGE AII INSURANCE COMPANY
SPECIALITY CLAIMS SERVICES
 CFC House
 Mamlaka Road
 PO Box 30390 - NAIROBI 00100
 Telephone: +254 020 3783000
 Fax: +254 020 2727800

OR

Wickfield House
 18-22 Disney Place
 London SE1 1HJ
 +44 (0) 20 7839 9650
 Facsimile+44(0)20 7407 9206

MEDICAL CERTIFICATE

CLAIM REFERENCE:

THIS CERTIFICATE TO BE COMPLETED BY THE USUAL DOCTOR OF THE PERSON WHOSE CONDITION GIVES RISE TO THE CLAIM. ANY CHARGE MADE FOR COMPLETION OF THIS DOCUMENTATION IS THE RESPONSIBILITY OF THE INSURED PERSON AND IS NOT REFUNDABLE BY THE INSURERS.

CLAIMANT'S DETAILS

Name:.....
 Date of Birth:.....

NAME OF PATIENT IF DIFFERENT FROM CLAIMANT

Patients Date of Birth:.....
 Relationship to Claimant:.....

PATIENT'S CONSENT FOR THE RELEASE OF MEDICAL INFORMATION

I authorise the medical practitioner named below to release any information required by the Insurers or their appointed agents to enable my claim to be processed.

Signed:.....Date:.....

MEDICAL CERTIFICATE CLAIM REFERENCE:

Dear Doctor,
 The above named Insured Person has submitted a claimed on their travel Insurance Policy. In order for us to process this claim, we would be grateful if you would respond to the questions below:
 How long have you been the patient's usual doctor?.....
 Precise nature of medical condition/illness/injury/cause of death:.....
 Date first consulted for this problem:.....
 Was the patient waitlisted for a hospital admission?.....
 Please advise dates of waitlist and admission as appropriate:.....

Please advise details of any relevant previous medical history, including any chronic and/or recurring medical problem of a serious nature which has necessitated consultation, medication or in-patient treatment over the last 30 months:.....

In your opinion, was the patient fit to travel as proposed? YES/NO
 Had the patient been given a terminal prognosis? YES/NO
 Is the patient pregnant?YES/NO
 If YES, please give E.D.D:.....

I,Dr:.....
 Confirm that the above information is correct.

Signed:.....

Qualifications:.....

Date:.....

Address:.....

Official Stamp.

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