INTANA

Guidance Notes For Curtailment (Early Return) Claims

Please submit originals of the following (photocopies are not acceptable, but we would suggest that you may wish to keep a copy for your own records): ✓

- The Insurance Certificate (Annual Certificates will be returned) or, if the insurance was purchased on the internet, a copy of the e-mail showing the insurance details ☐
- The booking invoice for your trip to confirm the full costs, deposits paid and date of booking ☐
- Evidence of any refund from the travel provider(s) ☐
- Correspondence received in respect of any medical declaration ☐
- Correspondence from your tour operator in confirmation of the total cost of the unused portion of your holiday (if available) ☐
- If the claim is due to bereavement, we will need to see the death certificate which will of course be returned ☐

CURTAILMENT

INTANA

Important Information

- **Original documents** need to be supplied.
  We recommend that you retain copies of all documentation forwarded to us.
- Please ensure that all questions are completed in full in BLOCK CAPITALS.

Note: If the information and documentation required is not provided your claim will not be processed.
If you are unable to provide the documentation required, you need to provide a written explanation.

The following documentation is required as part of your claim.

Please insert ✓ to indicate that documentation has been included.

Evidence of insurance	Insurance certification or details of insurance. These may be supplied with your booking itinerary / invoice.	☐
Completed claim form	Fully complete each section that is relevant to your claim and ensure you have signed the claim form.	☐
Booking details	A booking invoice confirms the full costs, deposits paid and date of booking.	☐
Additional expenses	Receipts for additional expenses incurred, including new flight tickets and new flight booking details.	☐
Completed medical declaration	The medical declaration document which forms part of this claim form needs to be completed, signed and stamped by the medical doctor of the patient whose illness necessitated your curtailment.	☐
Letter from treating doctor abroad	If curtailment was as a result of your medical condition, it is necessary to provide detailed reasons from the treating medical doctor abroad stating why it was medically necessary to curtail / extend your trip.	☐
Death Certificate	If the claim is due to bereavement, you will need to provide the death certificate. This document will be returned to you. A death certificate needs to be supplied together with a completed medical declaration.	☐

Claim Reference Number

CURTAILMENT

Claim Form

Please complete in **BLOCK** capitals ensuring all relevant fields are completed

Intana, Collinson Insurance Services Limited,
Claims Department, IDA Business Park, Athlumney, Navan, Co. Meath, Ireland

CLAIMANT DETAILS

Surname

Title Mr/Mrs/Ms/Miss/Other

First Name

Date of Birth

Address

Postcode

Home Telephone No

Work Telephone No

Mobile Telephone No

Occupation

Email Address

POLICY DETAILS

Policy Number

Date of Purchase

Purchased from:

Lead Name on Policy (If different from claimant)

Relationship to claimant

Is policy / lead name address different to claimants:

Yes

No

If Yes, please provide below:

Postcode

TRAVEL DETAILS

Country of Destination

Date Trip Booked DD / MM / YYYY

Departure Date DD / MM / YYYY

Return Date DD / MM / YYYY

Type of booking:

Packaged Holiday

Independent

DETAILS OF OTHER INSURANCES - Failure to provide the information requested below may delay your claim

Some bank accounts and credit cards come with Travel Insurance benefits and if you did have cover of this nature we may seek a contribution from the other company once your claim is settled. A loss that is covered by more than one policy will routinely be shared so each Insurer can keep their premiums as competitive as possible, but the contributing Insurer cannot alter the price of terms of its policy unless there has been a claim direct from a policyholder.

Name of Bank / Building Society

Type of Account — eg Platinum / Gold / Premier

Sort Code Account Number

IBAN

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Do you or any of the insured party have any other travel insurance that may cover you for this claim? Yes No

Name of Company

Policy Number

NAMES OF PEOPLE INSURED UNDER THIS POLICY

Names of people insured under this policy who curtailed and their relationship to the policyholder

	Name	Date of Birth	Relationship to policyholder	Medical screening reference if applicable
1				
2				
3				
4				
5				
6				

Have you approached your travel agent/tour operator to obtain a refund? Yes No

If yes, please advise amount refunded **£**

Were you able to use your original return tickets? Yes No

If no, please send your original tickets and enclose proof of purchase for new tickets.

CLAIM DETAILS

Additional Travel details. Please state reason for each section of your travel (ensure all receipts and flight tickets are enclosed).

	From	To	Cost £	Reason for travel
1				
2				
3				
4				
5				
6				

Actual return date DD / MM / YYYY

Total number of nights accommodation lost

Total cost of original Trip (excluding ski pack if applicable) £

(Unused accommodation will be calculated on a % basis based on nights of unused pre-booked accommodation. Please forward a booking invoice showing breakdown of accommodation costs).

Winter Sports Claim (if applicable)

Winter Sports

State winter sport / activity

Was the winter sport / activity carried out on piste or off piste? On piste Off piste

Lessons (per adult) £

Ski Pass (per adult) £

Equipment Hire (per adult) £

Total cost of ski pack (per adult) £

Date ski pack started DD / MM / YYYY

Date ski pack scheduled to expire DD / MM / YYYY

Date and time unable to use ski pass from DD / MM / YYYY HH:MM

CURTAILMENT DETAILS

Please give full details for the reason for curtailment and attach appropriate written confirmation.

(If the curtailment is for medical reasons you must include written confirmation from the treating doctor abroad that curtailment was medically necessary. If curtailment was due to a person not covered by this insurance, his/her GP must complete the medical declaration for a non-insured person.

Name of treating doctor ____________ Contact Details ____________

Date(s) of consultation ____________

Did you the contact your private medical insurance emergency service at the time of the incident? Yes ☐ No ☐

Date DD / MM / YYYY Time HH:MM Our Reference ____________

If no, please give a full and detailed explanation of why you failed to contact the emergency service:

(Failure to contact Intana Assist Emergency Services at the time of the incident may limit the amount of your claim. Please refer to your policy wording for further details).

NON-MEDICAL CURTAILMENT

Reason for curtailment:

Please provide official documentation to support the need to curtail your trip.

MEDICAL DECLARATION FOR AN INSURED PERSON

If this claim is related to a person insured under this policy then please complete this section (Pages 5 & 6). If this claim is due to a close relative, travelling companion who is not insured under this policy or person with whom you intend to stay then please complete the medical declaration for a non-insured person (Page 7).

Name of Patient

Booking Date DD / MM / YYYY Date insurance was purchased DD / MM / YYYY

This section should be completed by your GP in relation to the medical condition which necessitated your claim. Completion by a Hospital, Specialist or Consultant will not be accepted. Any charges incurred to obtain this information are not covered under your policy. Medical Records/Further Medical Information may be requested. (Doctors please write in **BLOCK** capitals and validate with surgery stamp. **Please complete all questions**).

Are you a GP at the patient's regular practice? Yes ☐ No ☐

Were you consulted in relation to the patient's intention to travel? Yes ☐ No ☐ If yes, Date DD / MM / YYYY

State (a) the medical condition(s) or (b) the cause of death, which resulted in this claim.

(a)

(b)

Date of first consultation for the condition(s)? DD / MM / YYYY Date of diagnosis of the condition(s)? DD / MM / YYYY

Date curtailment was recommended? DD / MM / YYYY

At the time of issue of the insurance (see above) was the patient fit to undertake the planned trip and not planning to travel against the advice of a Medical Practitioner? Yes ☐ No ☐

At the time of issue of the insurance (see above), did the patient have any symptoms for which he/she was awaiting investigations/consultation, and/or where the underlying cause had not been established)? If yes, provide full details below. Yes ☐ No ☐

If the claim arose from a complication of pregnancy please confirm:

(a) the diagnosed complication

(b) the date the pregnancy was confirmed DD / MM / YYYY (c) the estimated date of delivery DD / MM / YYYY

Signature(s) Date DD / MM / YYYY

MEDICAL DECLARATION FOR A NON-INSURED PERSON

If this claim relates to a close relative, travelling companion who is not insured under this policy or person with whom you intend to stay then please complete this section (Page 7).

Name of Patient

Relationship to the policyholder

Booking Date DD / MM / YYYY   Date insurance was purchased DD / MM / YYYY

This section should be completed by the Non-Insured person's GP in relation to the medical condition which necessitated the claim. Completion by a Hospital, Specialist or Consultant will not be accepted. Any charges incurred to obtain this information are not covered under your policy. Medical Records/Further Medical Information may be requested. (Doctors please write in **BLOCK** capitals and validate with surgery stamp. **Please complete all questions**).

Are you a GP at the patient's regular practice? Yes ☐ No ☐

State (a) the medical condition(s) or (b) the cause of death, which resulted in this claim.

(a)   (b)

Date of first consultation for the condition(s)? DD / MM / YYYY   Date of diagnosis of the condition(s)? DD / MM / YYYY

Date cancellation was recommended? DD / MM / YYYY

Prior to the date the insurance was purchased did the patient:

(a) require surgery, inpatient treatment or hospital consultation? DD / MM / YYYY

(b) require any form of treatment or prescribed medication? DD / MM / YYYY

Was the patient on a waiting-list for or had knowledge of the need for surgery, inpatient treatment or investigations at any hospital or clinic when the insurance was purchased? If yes, list below Yes ☐ No ☐

Did the patient receive a Terminal Prognosis when the insurance was purchased? Yes ☐ No ☐

If the claim arose from a complication of pregnancy please confirm:

(a) the diagnosed complication

(b) the date the pregnancy was confirmed DD / MM / YYYY   (c) the estimated date of delivery DD / MM / YYYY

Signature(s)   Date DD / MM / YYYY

Signature(s)   Date DD / MM / YYYY

GP Stamp **(CERTIFICATES CANNOT BE ACCEPTED WITHOUT THE APPROPRIATE DOCTOR'S STAMP)**

SETTLEMENT DETAILS

Claims payments made by BACS transfer or other electronic banking system can be made and credited to your account more quickly than a cheque.

By entering your bank account details, you confirm that Intana has your full authority to remit monies directly to that account by the BACS or other electronic banking system. You also accept that, providing payment remitted to the bank account designated by you, Intana shall have no further liability or responsibility in respect of such payment, and that it shall be your sole responsibility to make collection of any misdirected payment.

Name of account holder

Type of current account — eg Platinum / Gold / Premier

Name / Address of Bank / Building Society

IBAN

SWIFT BIC

THIRD PARTY AUTHORITY

Do you require a third party to handle this claim on your behalf — Yes ☐ No ☐

If yes, please complete the below

I / We authorise (name of Broker / nominated Third Party)

To handle this claim on My / Our behalf and agree that all communications in respect of the claim will be solely through them at the following address:

Postcode — Telephone Number

DECLARATION – please tick the boxes to confirm you agree with the following statements:

☐ I / We confirm that the information provided in this form and in any accompanying supporting documentation is true, accurate and complete to the best of all claimants' knowledge. The information provided with this claim may be shared with other insurers or financial institutions for the purposes of dealing with this claim and eliminating insurance fraud. In the event of false, inaccurate or incomplete information being provided the Insurer reserves the right to cancel your policy and reject your claim in full or part.

☐ I / We give authority to Intana (as agent of the relevant underwriter) and their appointed representatives to approach any third party who holds information relating to the incident giving rise to this claim, including, but not limited to medical practitioners and hospitals /clinics where the claim relates to a medical condition or injury. Such authority will permit the third party(ies) to release relevant information to Intana to assist in the investigation and resolution of this claim.

☐ I / We hereby grant Intana full rights of subrogation in respect of any payments made on behalf of all claimants. I / We further agree to fully co-operate with any such recovery efforts from liable third party or parties and to immediately notify Intana if any lost or stolen property mentioned in this claim form is subsequently recovered.

IMPORTANT

Please note that if you do not authorise your agent / third party to deal with the claim, we will not be able to discuss any details of the claim with them due to Data Protection Act regulations.

Signature(s) **X** **X** Date DD / MM / YYYY

Data Protection

Personal Data provided in this claim form or submitted as part of this claim will be used and processed by us in line with our Data Protection Privacy Notice which can be found in the latest published version of your Policy Wording, or which can be requested from us at any time.