Curtailment Expenses
Claim Form

Please complete this claim fully and return to us by following the postal instructions below.

For ERV.co.uk, ERV Express, Planet Earth, Eurocamp, Keycamp, Select Sites, Axiom, Cyclosure, starttravel.co.uk, all Coach Tours, Civil Service and ManxCover policies please return your completed form to:

ERV Insurance Services
PO Box 9
Mansfield
Nottinghamshire
NG19 7BL

For all other policies please return your completed form to:

Mayday Claims
2 Clifton Mews,
Clifton Hill,
Brighton,
BN1 3HR

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Please complete this claim form fully and return to us.
Please ensure that you quote your claim number on all correspondence.

Personal details

Title ☐ Mr ☐ Mrs ☐ Miss ☐ Ms — Other

Family name — First name

Date of birth (D D M M Y Y Y Y) — N.I number

Address

Post code

Daytime tel no. — Evening tel no

Email address — Occupation

Policy details

Company name *If applicable*

Policy number — Date of issue (D D M M Y Y Y Y)

Date of booking (D D M M Y Y Y Y) — Destination

Date of travel (D D M M Y Y Y Y) — Date of return (D D M M Y Y Y Y)

Travel agent — Tour operator

Claim details

Reason for curtailment

Names of all persons who curtailed their trip	Age	Relationship to claimant

Actual date of return (D D M M Y Y Y Y) — Number of unused nights

If curtailment was due to a medical condition of your party has a medical claim been submitted? ☐ Yes ☐ No

Was our medical emergency number contacted? ☐ Yes ☐ No

Date (D D M M Y Y Y Y) — Time — Claim number

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Particulars of claim

		Cost	
Nature of expenses	Provider	Local currency	Sterling

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Information we need from you for possible recovery opportunities

Your Travel Policy has conditions attached whereby you must provide us with any information that assist any recovery actions. This is a standard practice in the insurance market and contributions made from other insurance cover serve to keep the costs of your premiums down. The information provided should not affect your renewal premiums or no claims discount.

Please answer the following questions and provide details as required. For questions that require a YES / NO response, please tick the appropriate boxes. Failure to do so may delay your claim.

1. Do you have a bank account?	Yes ☐	No ☐

A bank account you hold may offer Travel Insurance cover as part of the benefits. Under no circumstances will your bank account information be used other than to obtain a contribution from the Travel Insurance provider. This will not affect your bank account in any way.

	Name of bank (e.g. HSBC)	Type of account	Account holder name	Account number

2. Was a credit card or debit card used to pay all or part of the trip cost? (Certain credit or debit cards provide an element of travel cover)	Yes ☐	No ☐

	Card issuer	Type of card e.g. Visa	Cardholder name	Card number

3. Do you have a Household Contents insurance policy? (Some household contents policies provide an element of travel cover)	Yes ☐	No ☐

	Name of Insurer		Policyholder name	Policy number

4. Do you hold any Private Medical Insurance?	Yes ☐	No ☐

	Name of Insurer		Policyholder name	Policy number

5. Do you consider anyone to blame for the incident?	Yes ☐	No ☐

If yes, please provide details.

It is a condition of the policy and your responsibility to provide sufficient documentation to support your loss. Failure to provide the required documentation, including the details of any other insurances, will delay and may invalidate the claim.

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Access to Medical Reports 1988

It may be necessary to apply for a medical report from a Doctor who has cared for you, and we ask that you give your consent by signing the claim form declaration. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988, and the procedures for dealing with the reports. You do not have to give your consent, but if you do, you can say whether you wish to see the report (or have a copy of it) before it is sent to us. If you say you wish to see the report, we must tell you at the same time as we write to the Doctor and we must tell him / her you wish to see the report. You have 21 days to contact the Doctor about arrangements for you to see the report.

Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied (if you ask). If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his / her costs.

Once you have seen a report, before it is sent to us, the Doctor cannot submit it until he has your written consent. You can write to the Doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your view on any part which he will not amend.

The Doctor is not obliged to let you see any part of a report if, in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctors intentions towards you or if disclosure would likely to reveal information about you or the identity of another person who has supplied information about you, unless that person has consented to the information relates to, or has been supplied by a health professional involvement in caring for you. In such cases, the Doctor must notify you in writing and you will be limited to seeing any remaining part of the report. If it is the whole of the report that is affected, he / she must not send it to us unless you give your written consent.

Preliminary Medical Certificate

To be completed by the usual medical practitioner of the ill / injured person. Please continue on a separate sheet of paper if necessary.

This information will be treated as PRIVATE AND CONFIDENTIAL. PLEASE COMPLETE IN BLOCK CAPITALS.

1. Patient name	
2. Patient age	
3. Are you the patient's usual Medical Practitioner?	
4. If so, for how long?	
5. a. State the date you first attended the patient for the present illness / injury. b. If for pregnancy reasons, give date confirmed & expected date of delivery.	
6. Please give a brief account, with dates of onset, course and progress of present illness / injury.	
7. Has the Patient received a terminal prognosis?	
8. a. Please provide dates and details of any in-patient treatment. b. Date placed on waiting list	
9. Has the patient suffered from the same or similar condition in the past? If the answer to this is YES, is the present illness, in your opinion, resulted in any way from the past condition?	
10. Has the patient been totally disabled from attending to any aspect of his /her business of occupation as a result of this condition?	
11. When did total disability cease? If continuing, when do you anticipate return to work?	
DOCTORS DECLARATION: I declare that I have examined the patient named above and / or have referred to their medical records and confirm that the information given above is a true and accurate statement, and further that no material information has been withheld.	*This section to be validated by surgery's stamp*

Print name		Signed	Date

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Claimants declaration and signature

1. I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement.
2. To the best of my knowledge and belief I have not omitted any material information which would affect the insurers assessment of this claim.
3. I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that 'ETI' will not accept any liability if any payments are not distributed proportionately to the persons concerned.
4. I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to 'ETI'. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act (AMRA) or other similar legislation.

I have read and understand the declaration above and included the necessary documents to substantiate my claim.

Claimant(s) full name(s)

Client's signature

Date D D M M Y Y Y Y

Full name of an authorised representative of the corporate policy holder (corporate and / or education group cover)

Signature of authorised representative

Date D D M M Y Y Y Y

I / We authorise _____ to act on my behalf in this matter.

Client's signature

Date D D M M Y Y Y Y