CLAIM FORM

Cancellation/Curtailment for Offsite Activities

ACE European Group
Claims Department
PO Box 4511
Dunstable LU6 9QA
tel: 0345 841 0059
fax: 0141 285 2901
e-mail: claims@acegroup.com

PLEASE WRITE IN BLACK INK AND USE BLOCK CAPITAL LETTERS.
ALL 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 Group Policyholder (Council)	Policy number
Name of School	

MAIN POLICYHOLDER DETAILS

Title	First name	Last name
Email address		Date of birth (DD/MM/YYYY)
Full address		
		Postcode
Contact no. Daytime	Contact no. Evening	
For security purposes please provide a password which will be required to access your claim information *This is for additional security and you may be asked for it when calling ACE.*		

INSURED PERSONS DETAILS

Full name	Date of birth (DD/MM/YYYY)	Relationship to main policyholder	I intend to claim on behalf of: (✓) where applicable

insured.™

eduvia.com

TRAVEL DETAILS

Type or travel: Offsite Activity/School Trip _____

Please give the reason for cancellation/curtailment/rearrangement of the journey: _____

_____

_____

_____

_____

Please state the **scheduled** times of travel: Outward Date: _____ Return Date: _____

Date Journey Booked: _____ Date of Cancellation/Curtailment/Rearrangement: _____

Please provide a copy of your original itinerary / travel documents if available.

If the cancellation/curtailment/rearrangement was due to **illness** or **injury** please state:

(a) the name and age of sick/injured person: _____

(b) the exact nature of illness/injury and the commencement date: _____

_____

_____

_____

_____

_____

_____

(c) has the person concerned previously suffered the same or a similar complaint? YES / NO

If YES please give the relevant dates: _____

If journey was **cancelled** please give details of expenditure incurred: _____

_____

_____

_____

_____

_____

_____

Total Amount Paid: _____ Total Amount Refunded: _____ Amount to be Claimed: _____

Please provide a cancellation invoice together with your travel documents from your tour operator, transport carrier or accommodation agent.

If journey was **curtailed** please provide details of additional travel and sundry expenses including how these were incurred:

Receipts need to be enclosed for these charges: _____

_____

_____

_____

_____

_____

_____

Please provide medical evidence from the attending doctor or please ask the attending doctor to complete the following:

Nature of complaint preventing travel: _____

_____

_____

_____

_____

Date treatment first sought: _____

Was cancellation of the journey medically necessary? YES / NO

VALIDATION STAMP

_____ _____

SIGNED DATE

ACCESS TO MEDICAL REPORTS ACT 1988

Before your attending 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 ACE 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 ACE

   ☐ I **DO NOT** wish to see the report before it is sent to ACE
3. I authorise such Doctor to disclose such information to ACE.
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:-

Name of your Bank/Building Society: _____

_____ *Bank*

Address _____

_____

_____

_____ Postcode _____

Bank Sort Code

Account Number _____

Name of Account Holder(s) _____

_____

DATA PROTECTION

The information that you and your medical representative have provided in the claim form and Doctor's Statement is 'sensitive data' as defined by the Data Protection Act 1998. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by ACE European Group Limited and its group companies. It may be held on computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive 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 sensitive personal data for the above purposes. You also consent to our transferring your information to countries which do not provide the same level of data protection as the UK, if necessary for the above purposes. If we do make such a transfer we will, if appropriate put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm that they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

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 return the completed claim form together with any enclosures to ACE European Group Limited 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

☐ Your attending physician has completed and signed where applicable

As failure to do so will result in delay in handling your claim.

ACE European Group Limited is registered in England and Wales registered number 01112892, registered office 100 Leadenhall Street, London, EC3A 3BP. Authorised by the Prudential Regulation Authority and regulated by the Financial Conduct Authority and the Prudential Regulation Authority, reference number 202803. This can be checked on the Financial Services Register at www.fca.org.uk/register or by contacting the FCA on 0800 111 6768.