

# Claim form

## Cancellation, Curtailment or Rearrangement

T: 1 800 242 467 or  
 +353 (0)1 440 1766

### Data protection

We use personal information which you supply to us [or, where applicable, to your insurance broker] for underwriting, policy administration, claims management and other insurance purposes, as further described in our Master Privacy Policy, available here: <https://www2.chubb.com/ie-en/footer/privacy-policy.aspx> or by searching 'Master Privacy Policy' on <https://www2.chubb.com/ie-en/>. You can ask us for a paper copy of the Privacy Policy at any time, by contacting us at [dataprotectionoffice.europe@chubb.com](mailto:dataprotectionoffice.europe@chubb.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.

Once completed please email to [travel@ie.sedgwick.com](mailto:travel@ie.sedgwick.com) and include any supporting documentation.

### Policy number

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### Main Policy holder details

<b>Title</b>	<b>First name</b>	<b>Last name</b>	
_____	_____	_____	
<b>Email address</b>		<b>Date of Birth (DD/MM/YY)</b>	
_____		_____	
<b>Full address</b>			
_____			
			<b>Postcode</b>
_____			_____
<b>Contact no. (day)</b>		<b>Contact no. (eve)</b>	
_____		_____	

### Insured persons details

<b>Full name</b>	<b>Date of Birth (DD/MM/YY)</b>	<b>Relationship to main policy holder</b>	<b>I intend to claim on behalf of: (✓) where applicable</b>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

## Travel details

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Type of travel: Business:  Holiday:  Date of 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 patient ever suffered with this or any similar condition before the present episode? 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: \_\_\_\_\_

**Please use validation stamp or complete in block capitals:**

**Signature**

Date: \_\_\_\_\_

Validation stamp
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**Explicit Consent to use Health Information- Important Please Read**

We carefully assess your claim, and also take steps, in common with standard industry practice, to monitor for fraudulent claims. For these reasons, we may need to use information about your health which is relevant to your claim, and, where relevant, the health of other persons relevant to the claim which you provide to us. **You must ensure that any other persons whose information you provide to us understand and do not object to this use of their data, and (where required under applicable law) consent to us using their information for the purposes described here.**

We will not use this health information for any other purpose, and will comply at all times with the terms (including security standards) referred in our Privacy Policy. You do not have to provide us with the following consent, and you may withdraw it at any time, but if you do not provide it, or choose to later withdraw it, that may affect our ability to process your claim.

Please tick the following box to indicate your consent to our use of your health information in this way.

**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 Sort Code
_____	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Address:	IBAN
_____	_____
_____	BIC
_____	_____
_____	Account Number
_____	_____
_____	Name of Account Holder (s)
_____	_____
_____ Postcode _____	_____

**Declaration**

I declare that all the information given is to the best of my knowledge and belief, full true and correct. I give permission for any Medical Practitioner, Law Enforcement Agency or Statutory/Regulatory Authority mentioned with respect to this claim, to release information regarding my records.

\_\_\_\_\_  
**Signed**

\_\_\_\_\_  
**Name**

\_\_\_\_\_  
**Date**

**Checklist**

Please return the completed claim form together with any enclosures to your insurance broker or to Chubb and please ensure:

- You have complete 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 doctor fully completes the statement

If you do not complete all sections and provide all requested documentation your claim will be delayed.

**Chubb. Insured.<sup>SM</sup>**

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Chubb European Group SE is an undertaking governed by the provisions of the French insurance code with registration number 450 327 374 RCS Nanterre and the following registered office: La Tour Carpe Diem, 31 Place des Corolles, Esplanade Nord, 92400 Courbevoie, France. Chubb European Group SE has fully paid share capital of €896,176,662.