General Insurance Co. Ltd.
The Tradition Continues...

9-11 Bridge Street, Castries,
St. Lucia, West Indies.
T: 1 (758) 458-8216
F: 1 (758) 458-8259
E: mcinsure@mandcgroup.com

CANCELLATION/CURTAILMENT/MISSED DEPARTURE TRAVEL DELAY/PERSONAL LIABILITY CLAIMS FORM

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.

A. PERSONAL DETAILS

Date of Birth

Occupation

Telephone

Hours of Contact
(at above number)

B. INSURANCE DETAILS

Policy Name

Travel Dates From To

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

Hotel Accommodation details Resort Country

C. CANCELLATION/LOSS OF DEPOSIT/CURTAILMENT

Reason for Cancellation or Curtailment

(i) For Cancellation/Loss of Deposit

Date Trip originally booked Total Cost of holiday

Date Insurance purchased Amount Refunded

Date Trip Cancelled Amount Claimed

(ii) 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 MUST BE COMPLETED BY THE USUAL DOCTOR OF THE PERSON WHOSE CONDITION GIVES RISE TO THE CLAIM

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

D. MISSED DEPARTURE/TRAVEL DELAY

Reason for Delay or Missed Departure:

(i) 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

(ii) 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 accommodation expenses (if applicable)	YES/NO
6. Confirmation of cause of claim from carrier, breakdown organisation 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

DECLARATION

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

Signed Date

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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

PATIENT'S DATE OF BIRTH RELATIONSHIP TO CLAIMANT

PATIENT'S CONSENT FOT THE RELEASE OF MEDICAL INFORMATION

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

Signed Date

Dear Doctor,
The above named Insured Person has submitted a claim 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 the 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

Had the patient been given a terminal prognosis?

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