Cancellation/Curtailment Claim Form

THANK YOU FOR NOTIFYING US OF YOUR CLAIM
PLEASE COMPLETE ALL QUESTIONS - IF ANY QUESTION IS NOT APPLICABLE PLEASE STATE "N/A"

Name of Institution (University, College etc):

Certificate No:

Date on which Travel commenced or was due to commence:

Full Name of Person Covered: Date of Birth:
Title (Mr, Mrs, Miss, Ms):

Full Address:

Postcode:

Tel No. (Business): (Home):

Email:

Full Name of other Persons Covered	Date of Birth	Relationship
1		
2		
3		

PLEASE ENSURE YOU SIGN THE DECLARATION ON THIS CLAIM FORM

TRAVEL DETAILS

Type of Travel: Business/Holiday

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

Please state the schedules times of travel:

Outward Date: Return Date:

Date Journey Booked: Date of Cancellation/Curtailment:

Please provide a copy of the original itinerary/travel documents

If the cancellation/curtailment 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:

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

Validation Stamp:

Nature of complaint preventing travel:

Date treatment sought:

Was cancellation of the journey medically necessary? YES/NO

Signed: _____ Date: _____

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, transporter 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.

DECLARATION

I declare that the information given is to the best of my knowledge and belief, full, true and correct.

Signed: _____Date: _____

ACCESS TO MEDICAL REPORTS ACT 1998

Before a doctor can give a medical report on this claim form, which is a requirement of this claim, the Person Covered must give their consent. Before giving consent, they should be aware of their rights under the Act which are summarised as follows:

1. They may withhold their consent.
2. They may see the report before it is sent to us within 21 days from the date of this report.
3. They may ask to see the report for up to six months After the report is completed.
4. They may ask the doctor to amend any part of the Report which they consider to be incorrect or Misleading. If the doctor does not agree with their request the Person Covered may attach their comments to this report.

NB The doctor may withhold all or part of this report From the Person Covered if he considers that they 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 1998 in connection with my claim

1. I hereby consent to UMAL seeking medical information from any doctor who at the 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 UMAL
   ☐ I DO NOT wish to see the report before it is sent to UMAL
3. I authorise such doctor to disclose such information To UMAL
4. I agree that a copy of this consent shall have the validity of the original.
5. I agree that UMAL may share any information obtained, in confidence, with Arch Insurance Company (Europe) Ltd

Signed: _____Date: _____

PLEASE ENSURE

☐ You have completed ALL relevant questions on this claim form.

☐ You have enclosed all requested information/documentation.

☐ You have signed this claim form.

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

Please return the completed claim form together with any enclosures to:-
U M Association Ltd., Hasilwood house, 60 Bishopsgate, London EC2N 4AW