Dear Claimant,

Re: Cancellation Claim

We are sorry that an incident has occurred during your trip. Please find attached a claim form. Please ensure this is fully completed, signed and returned to us by post, together with the following **original** documentation.

1- Proof of your insurance. This may be in the form of a holiday booking invoice or for Internet bookings, an email confirmation.
2- The Airlines booking invoice or proof of travel and payment of trip.
3- Airline cancellation invoice. If you are travelling with a 'ticket-less' airline, please provide written confirmation from the airline that the booking has not been used and no refunds issued. For non-package trips, we require written confirmation from the transport/accommodation providers that there is no refund available.
4- Documentation in support of your need to cancel*.

* If cancellation is due to medical reasons, the medical certificate on the reverse of the claim form must be fully completed by the usual *family or treating doctor* of the person whose medical condition gives rise to this claim, regardless of whether they were due to be travelling or not. In the event of bereavement, a copy of the death certificate will also be required.

If any of the above cannot be provided, please enclose a covering letter explaining the reasons for this.

Please note that in order for us to handle your claim as quickly and efficiently as possible, it is necessary that you answer all questions and forward **original** documents. We suggest that you retain photocopies of all relevant documents for your own records. **Please ensure you make it clear who you wish any payment to be made out to on the front of the claim form, if not the claimant**.

The address to return your completed claim form and supporting documentation to is as follows:

Travel Claims Department,

Arab Gulf Health Services
NEXtCARE, Eiffel Boulevard Limited Building
(Eiffel 2) 1st floor,
Umm Al Sheif,
Sheikh Zayed Road
PO80864
Dubai UAE
Phone: **UAE +971 4 270 8705**
Email: **travel.claims@nextcarehealth.com**

We look forward to hearing from you.

Yours faithfully,
Travel Claims Department
NEXtCARE

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CLAIM FORM

Please ensure all original documents requested are enclosed Claim Reference No.:

Personal Details

Surname: Forename(s):

Title: Date of Birth: Address:

Occupation:

Daytime Tel No: Postcode:

Evening Tel No: Mobile No:

E-mail Address:

Cheque to be made payable to:

Trip Details

Destination / Country of this Journey:

Date Journey Booked: Date Insurance Purchased:

Date of Journey: Date of Return:

Duration: days No. of People Insured: Place Insurance Purchased:

Name of Tour Operator (if applicable):

Travel Insurance Details

Travel Insurance Policy No/Ref:

What company did you buy your Travel Insurance from?

Other Insurance: Please confirm which Bank you hold current accounts and / or credit cards with:

Bank Name Credit Card No.

Issued Bank

Date of Expiry

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MEDICAL CERTIFICATE

Claim Reference No.:

This form must be completed by the family or treating doctor of the person whose medical condition gives rise to this claim. Any fee for completing this certificate is the responsibility of the patient / claimant.

Name of patient:

Date of birth: How long have you been the patient's *family or treating doctor*?

Please confirm exact diagnosis:

Date first diagnosed: Date symptoms first began:

Details of any previous medical history relevant to the above condition including the date of diagnosis:

Has the patient been in hospital in the last 12 months prior to booking the journey? If yes, please provide details:

At the time the journey was booked was the patient? (If yes to any of the questions please provide details):

On a waiting list:	Yes	No
Taking any medication:	Yes	No
Undergoing any tests:	Yes	No
Aware of the condition:	Yes	No
Given a terminal diagnosis:	Yes	No

In your opinion:

a) Was cancellation medically necessary? Yes No

b) When did cancellation become medically necessary? Date

c) Was the patient's medical condition stable and under control at the time of booking? Yes No

Name of Family or treating doctor:

Contact number:

Name & Practice (Stamp Group)

Signature: Date:

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CANCELLATION CLAIM FORM

Please ensure all original documents requested are enclosed

Date cancellation became necessary: _____ Date of cancellation: _____

If there is a difference in dates, please explain:

_____

Please advise exact cause of cancellation. If cause of cellation is not of a medical nature, you need to provide suitable documentation in support of your need to cancel.

_____

Amount Claimed (in local currency or US dollars)

Total journey cost	
Less refunds received	
Less airport departure tax (if applicable)	
Total Amount Claimed	

Please list all persons cancelling and their relationship to the claimant

Name	Relationship	Age

If cancellation was due to an injury caused by a third party, please provide their contact details:

_____

Please give details of any previous claims for cancellation or state 'No': _____

Name & Address of Insurer: _____

Policy / Reference Number: _____

Declaration: Insurers and their agents share information to prevent fraud and for underwriting purposes. It is a criminal offence to make a fraudulent claim. Cases are investigated and any person suspected of fraud is reported to the police with whom we always co-operate in effecting a prosecution. I/We declare that the information contained within this claim form is true and correct to the best of my/our belief. I/We assign to Insurers all rights of recovery/salvage against any person or organization and will do whatever else is necessary to secure such rights. I/We agree that Insurers may contact our *family or treating doctor* for more information if they deem it necessary.

Claimant Name _____ Signature _____ Date _____