Chubb European Group SE
Travel Insurance Claims
Sedgwick, Merrion Hall,
Strand Road,
Sandymount, Dublin 4

Telephone: 1800 719 420 or
+353 (0)1 440 1757

Claim form
Cancellation, Curtailment or Rearrangement

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.

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 and include any supporting documentation.

Policy number

Main Policy holder details

Title	First name	Last name

Email address

Date of Birth (DD/MM/YY)

Full address

Post code

Contact no. (day)

Contact no. (eve)

Insured persons details

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

Travel details

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

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: _____

Address: _____

_____

_____

_____

Postcode: _____

Bank Sort Code ☐☐ ☐☐ ☐☐

IBAN _____

BIC _____

Account Number _____

Name of Account Holder (s) _____

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.℠