Aon UK Limited
Aon Underwriting Managers

Report Form for Cancellation or Curtailment Claim

This file is a fillable electronic pdf form. Please complete all questions – if any question is not applicable please state "N/A".

Insured Details

Name of Policyholder

If a subsidiary of the policyholder please provide company name

Policy Number

Relationship to Policyholder Director ◯ Employee ◯ Student ◯ Contractor ◯ Volunteer ◯ Consultant ◯ Other ◯

If Other – *Please provide details*

Full Name of Insured Person

Mr ◯ Mrs ◯ Miss ◯ Ms ◯ Date of Birth d d / m m / y y y y

Insured Person's Full Address

Street

City County

Country Postcode

Email Tel Fax

For security purposes please provide a password which will be required to access your claims information

Full Name of Claimants

	Date of Birth d d / m m / y y y y	Relationship to the Insured Person eg, Partner, Son, Daughter
	Date of Birth d d / m m / y y y y	Relationship to the Insured Person eg, Partner, Son, Daughter
	Date of Birth d d / m m / y y y y	Relationship to the Insured Person eg, Partner, Son, Daughter

Travel Details

Type of Travel Business ◯ Holiday ◯

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

Please state the scheduled times of travel

Outward Date d d / m m / y y y y

Return Date d d / m m / y y y y

Date journey booked d d / m m / y y y y

Date of Cancellation/Curtailment d d / m m / y y y y

Please provide a copy of your original itinerary/travel documents if available

If the cancellation/curtailment was due to illness or injury, please state

a The name and age of sick/injured person

Age

b The exact nature of illness/injury and the commencement date

c Has the person concerned previously suffered the same or similar complaint? Yes No

If **Yes**, please give the relevant dates d d / m m / y y y y d d / m m / y y y y d d / m m / y y y y

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

Please use validation stamp or complete in block capitals

Name

Address

Telephone

Doctor's Validation Stamp

Nature of complaint preventing travel

Date of treatment first sought d d / m m / y y y y

Was the cancellation of the journey medically necessary? Yes No

Signed

Date d d / m m / y y y y

If journey was cancelled, please give details of expenditure incurred

Total Amount Paid Total Amount Refunded Amount to be Claimed

Airport Taxes should be refunded by your Airline Company or travel agent – you should consult them direct for reimbursement.
Please provide a copy of the refund document

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.

Access to Medical Reports Act 1988

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

1 You may withhold your consent.

2 You may see the report before it is sent to us within 21 days from the date of this report.

3 You may ask to see the report for up to six months after the report is completed.

4 You may ask the doctor to amend any of the report which you consider to be incorrect or misleading. If the doctor does not agree with your request you may attach your comments to the report.

NB The doctor may withhold all or part of the report from you if it is considered that you 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 1988 in connection with my claim:

1 I hereby consent to Insurers or their representative seeking medical information from any doctor who at any 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 Insurers or their representative. ◯

I DO NOT wish to see the report before it is sent to Insurers or their representative. ◯

3 I authorise such doctor to disclose such information to Insurers or their representative.

4 I agree that a copy of this consent shall have the validity of the original.

Signed

Date d d / m m / y y y y

Data Protection

In order to administer your claim, this information will be used by Chubb European Group Limited and Aon UK Limited. It may be held on computer and/or in manual files for administration and risk assessment purposes. We may disclose your personal data and sensitive data to reinsurers, the policyholder and the AuMine claims database, and may request information from other insurance companies for underwriting, claims handling and fraud prevention purposes.

By returning this form, you consent to our processing your sensitive personal data for the above purposes. You also consent to our transferring your information to countries (which do not provide the same level of data protection as the UK) if necessary for the above purposes. If we do make such a transfer we will, if appropriate, put a contract in place to ensure your information is protected.

Where you have provided information about another person, you confirm they have appointed you to act for them, to consent to the processing of their personal data, including sensitive data, to the transfer of their information abroad and to receive on their behalf any data protection notices.

Conflicts of Interest

Please note: Aon Underwriting Managers (AUM) is a Managing General Agent which is part of Aon UK Limited and is authorised by the Insurer to handle claims under the AonProtect scheme and will do so under the terms and conditions of the policy. Aon Underwriting Managers are therefore acting for the insurer. Any objection to this arrangement should be raised when first reporting the claim.

Declaration

By signing/inputting my name below and submitting this form I consent to the above data protection disclosure and I declare that all information given is to the best of my knowledge and belief, full, true, accurate and correct. **Please print and sign.**

Print Name **Signed** **Date** d d / m m / y y y y

Payee Advices

All claims payments will be issued payable to the policyholder (your employer/company) and not the claimant unless Aon Claims has received prior authorisation to pay the claimant direct.

However, if you are the claimant and require any payment to be made to yourself, your Company Insurance Administrator or Line Manager will need to provide written/emailed authorisation to Aon Claims.

Bank Details

When the claim has been approved and once we have received written confirmation from the policyholder to issue any payments due direct to the claimant, you may have the payment credited direct to your bank account. This payment method is both speedier and safer than payment by cheque. If you would like to take advantage of this arrangement, please complete the following:

Bank name ______ Sort Code ______ Swift Code ______

IBAN Code ______

Bank Address ______

Account Name ______

Account Number ______

Documents Required

Original travel documents (*these can be returned to you where necessary*)	Enclosed ◯	To follow ◯
Original itinerary	Enclosed ◯	To follow ◯
Cancellation invoice	Enclosed ◯	To follow ◯
Confirmation from booking agency/airline/tour operator that monies paid are not/partially refundable	Enclosed ◯	To follow ◯
Written confirmation from GP that insured person and/or the insured person's relative was fit to travel at the time of the original booking	Enclosed ◯	To follow ◯
If cancellation is not due to medical reasons, the relevant documentation to indicate the reason for cancellation and why it was beyond the control of insured person/s	Enclosed ◯	To follow ◯

Please Ensure

1. You have completed ALL relevant questions on the claim form.
2. You have enclosed all requested information/documentation.
3. You have signed this claim form.
4. The attending doctor has completed and signed where applicable.

Failure to do so will result in a delay in handling your claim.

Thank you for completing this form.

IMPORTANT

Please print and sign this form and return to:

Insurance Team
University of Oxford Finance Division
23-38 Hythe Bridge Street
Oxford
OX1 2ET

t +44 (0)186 561 6078

Or scan and email to: **insurance@admin.ox.ac.uk**

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