CLAIM FORM

Cancellation, Curtailment or Rearrangement

ACE European Group
ACE Travel Insurance Claims
OSG, Merrion Hall, Strand Road,
Sandymount, Dublin 4
tel: 1800 719 420 or
+353 (0)1 440 1757

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.

Policy no.		
MAIN POLICYHOLDER DETAILS		
Title	First name	Last name
Email address		Date of birth (DD/MM/YYYY)
Full address		
		Postcode
Contact no. Daytime	Contact no. Evening	
For security purposes please provide a password which will be required to access your claim information *This is for additional security and you may be asked for it when calling ACE.*		

INSURED PERSONS DETAILS			
Full name	Date of birth (DD/MM/YYYY)	Relationship to main policyholder	I intend to claim on behalf of: (✓) where applicable
MAIN POLICYHOLDER AS ABOVE			

insured.™

TRAVEL DETAILS

Type or travel: Business / Holiday _____

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 person concerned previously suffered the same or a similar complaint? 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

VALIDATION STAMP

_____ _____

SIGNED DATE

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 _____

_____

_____

_____

IBAN _____

BIC _____

Account Number _____

Name of Account Holder(s) _____

_____

_____

DATA PROTECTION

Any information that you or your medical representative provides in the claim form and/or Doctor's Statement is "sensitive data" as defined by the Data Protection Acts of 1988 and 2003. Sensitive data includes any information about your physical and mental health. We require your consent before we can process this or any other such sensitive data that you may have already provided us with or may do so in the future.

In order to administer your claim, this information will be used by ACE European Group Limited and its group companies. It may be held in computer and or in manual files for administration, and risk assessment purposes. We may disclose your personal data and sensitive data to, and may request information from other insurance companies and private investigators 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 Ireland, 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. Guidelines for sharing of information in this regard are contained in a Code of Practice on Data Protection for the Insurance Sector which has been approved by the Data Protection Commissioner.

Where you have provided information about another person, you confirm that 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.

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 DATE

CHECKLIST

Please return the completed claim form together with any enclosures to your insurance broker or to ACE European Group Limited and please ensure...

☐ You have completed **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 physician has completed and signed where applicable

If you do not complete all sections and provide all requested documentation your claim will be delayed.