Traveller's Policy Claim Form

Allianz Insurance plc | Claims

Please complete and return this form to:

Address Stamp of Issuing Office

Policy Holder Details (Please insert)

Name

Policy Number

Address

Postcode

Age

Occupation

Tel. No Home

Tel. No Work

Claimant's Name

Address

Postcode

Age

Occupation

Tel. No Home

Tel. No Work

Tour Operator's Name and Address Travel Agent's Name and Address

Tel No.

Travel Agent's Name and Address

Tel No.

Was any other Travel Insurance Arranged? **Yes** ☐ No ☐

If **Yes** please provide name and address of Insurers and Policy Number

Please complete the following sections as appropriate, plus the declaration on the last page

Baggage/Money

Loss of Baggage, Money or Passport

Date of Loss or Damage

Time

Place

State in detail, precise circumstances in which loss or damage occurred

Where and to whom was the loss or damage reported (eg. Police Airline Authority)

Address

Postcode

Date

Time

Reference Number

Baggage/Money *(Continued)*

N.B. If baggage lost or damaged whilst in hands of the Airline, please attach Property Irregularity Report.

Name of your Household Contents Insurers

Policy Number

Address

Postcode

Baggage

Description of Lost or Damaged Property	Owner of Property	Date Purchased	Price Net Paid (Attach original receipts)	Net Amount claimed after allowing for wear and tear and depreciation

Personal Money

Description, Value and Currency of Money Lost or stolen (please specify whether Cash, Travellers Cheques etc.)	Amount Claimed

Loss of Passport

Please provide details of expenses incurred and attach original receipts. Please also explain why the expenses were incurred.

Details of Expenses	Amount Claimed

Medical and Other Expenses and Hospital Confinement

Nature of Illness

Duration of Illness or the effects of Injury

From To

Briefly describe how the injury occurred

(Continued)

N.B. Please also complete the medical information section on the last page of this claim form.

Was the E11 obtained from your local Post Office before departure? **Yes** ☐ No ☐ If **Yes** please provide details of your form.

Please provide details of your Private Health Insurers

Name

Policy Number

Address

Postcode

Details and Nature of Medical and Other Expenses Incurred (attach original receipts)

Amount Claimed

Hospital Confinement Benefit

Where you admitted to Hospital as In-Patient as a result of an accident or illness? **Yes** ☐ No ☐

Nature of Injury

Date and Time admitted am/pm Date and Time discharged am/pm

From To

You should enclose an original letter from the Hospital confirming the dates of admittance and discharge

Cancellation. Curtailment, Delay and Missed Departure

Date Holiday Booked

Please attach original booking invoice and conditions

Date and Time of Scheduled Departure am/pm Date of Cancellation or Curtailment am/pm

From To

Reason for cancellation or curtailment (attached original cancellation invoice if applicable)

N.B. If caused by death, injury or illness, please also complete the medical Information Section on the last page of this claim form.

If the sick/injured person is someone other than the Claimant, please advise his/her name and address and the relationship to the Claimant

Name Relationship

Address

Postcode

Are any charges recoverable? **Yes** ☐ No ☐ If Yes please give details and advise what steps have been taken to recover such sums

Amount(s) Claimed (attach original receipts)

Travel Delay

Length of Delay Cause of Delay

Documentary evidence must be supplied by the Travel Agent/provider of travel service confirming length and cause of delay.

Missed Departure

Please provide details of expenses incurred and attach original receipts

Details of Expenses

Amount Claimed

We will also require written confirmation of the failure of the transport service, from the carrier involved

Personal Accident

Accident - Date and Time admitted ______ am/pm ______ Location ______

Give full description of the circumstances and details of the injury

Medical Information

Name and Address of Doctor giving treatment in respect of the illness or injury

Has the person concerned ever suffered from this type of illness before? **Yes** ☐ No ☐

If **Yes** please give details

Name and Address of usual Doctor

Has he/she been consulted in respect of this illness or injury? **Yes** ☐ No ☐

When and why was he/she last consulted by the person concerned?

Signature (required for all claims)

Data Protection Notification

We may use personal and business details you give us, or which are supplied by third parties, to consider your claim, to search the files of credit reference agencies who may keep a record of the search, to carry out such financial and other enquiries as we consider necessary to evaluate the claim and assist in making a decision regarding the claim, and for compliance business reviews. We may also share these details with other insurance organisations and selected other parties to handle claims and prevent fraud. Personal details may be transferred to countries outside of the EU. They will at all times be held securely and handled with the utmost care in accordance with all principles of UK law. We will store such personal details on computer but will not keep them for longer than necessary. Under terms of the Data Protection Act 1998, individuals are entitled to a copy of all the information we hold about them.

VERY IMPORTANT – FRAUDULENT AND EXAGGERATED CLAIMS

Deliberately exaggerated claims could invalidate your policy cover. Insurance fraud is a crime and liable to prosecution.

The above answers to our questions will be the basis of consideration of your claim. You must ensure that all information is **true and correct** to the best of your knowledge and belief, and that all material facts have been disclosed.

A material fact is one that is likely to influence us in the assessment or acceptance of this claim, or one that is likely to influence our consideration of cover under the terms of your policy.

If you are in any doubt as to whether a fact is material, **you must disclose it**.

FAILURE TO DO THIS MAY MEAN THAT YOUR POLICY BECOMES INVALID AND A CLAIM PAYMENT WILL NOT BE MADE.

I declare the foregoing particulars to be correct to the best of my knowledge and belief. You have my permission to obtain further details from the Doctor(s) mentioned above.

Signature of Policyholder ______ Date ______

Signature of Policyholder ______ Date ______

Allianz Insurance plc. Registered in England number 84638. Registered Office: 57 Ladymead, Guildford, Surrey GU1 1DB Allianz Insurance plc is a member of the Association of British Insurers and the Financial Ombudsman Service. Allianz Insurance plc is authorised and regulated by the Financial Services Authority.

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