

# Claim Form



## Delayed Baggage

**Aviva**

Travel Claims  
PO Box 432  
Chichester  
West Sussex  
PO18 8UE  
Tel: 01243 621416  
Email: avivatravellclaims@cegagroup.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.

Name of Policyholder <b>CLEVELAND POLICE FEDERATION JBB</b>	Policy no. <b>25110273ECA</b>
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### 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	

Please complete the information below as we will need this to check your cover with the Federation Office.

<input type="checkbox"/> <b>SERVING OFFICER</b>	<input type="checkbox"/> <b>POLICE STAFF</b>	<input type="checkbox"/> <b>RETIRED</b>
RANK _____	STAFF No. _____	
COLLAR/POLICE ID No. _____	PAY OFFICE _____	
PAY OFFICE _____		

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 Aviva.

### INSURED PERSONS DETAILS

Full name	Date of birth (DD/MM/YYYY)	Relationship to main policyholder	I intend to claim on behalf of:
<b>IF NOT MAIN POLICYHOLDER AS ABOVE PLEASE STATE NAME BELOW AND OTHER REQUESTED DETAILS</b>			



## PAYEE'S BANK DETAILS

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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: 

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Account Number: \_\_\_\_\_

Name of Account Holder(s): \_\_\_\_\_

## DATA PROTECTION

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Information You or the Insured Person supplied may be used for the purposes of insurance administration by Us, its associated companies and agents, by reinsurers and Your intermediary. It may be disclosed to regulatory bodies for the purposes of monitoring and/or enforcing of Our compliance with any regulatory rules/codes. Your and the Insured Person(s) information may also be used for offering renewal, research and statistical purposes and crime prevention. It may be transferred to any country, including countries outside the European Economic Area for any of these purposes and for systems administration. In assessing any claims made, We or Our agents may undertake checks against publicly available information (such as electoral roll, county court judgements, bankruptcy orders or repossessions). Information may also be shared with other insurers either directly or via those acting for the Us (such as loss adjusters or investigators).

With limited exceptions, and on payment of the appropriate fee, You or the Insured Person have the right to access and if necessary rectify information held.

## DECLARATION

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I declare that all the information given is to the best of my knowledge and belief, full true and correct.

\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE

## TO BE COMPLETED AT THE FEDERATION OFFICE Where possible please endorse with official stamp

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I certify that the claimant is a member of the Scheme.

USE OFFICIAL STAMP
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\_\_\_\_\_  
SIGNED

\_\_\_\_\_  
DATE

## CHECKLIST

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Please return the completed claim form together with any enclosures to Federation Office 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

As failure to do so will result in delay in handling your claim.