Claim Form

Cancellation/Curtailment

Aviva
Travel Claims
PO Box 432
Chichester
West Sussex
PO18 8UE
Tel: 01243 621416
Email: avivatravelclaims@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	Policy no.
CLEVELAND POLICE FEDERATION JBB	25110273ECA

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.

☐ **SERVING OFFICER**
RANK
COLLAR/POLICE ID No.
PAY OFFICE

☐ **POLICE STAFF**
STAFF No.
PAY OFFICE

☐ **RETIRED**

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:
IF NOT MAIN POLICYHOLDER AS ABOVE PLEASE STATE NAME(S) BELOW AND OTHER REQUESTED DETAILS			

TRAVEL DETAILS

Please provide a copy of your original itinerary/travel documents.

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

Please state the **scheduled** times of travel:

Date of departure: _____ Date of return: _____

Date journey booked: _____ Date of Cancellation/Curtailment: _____

If the cancellation/curtailment 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 ACCOMODATION AGENT.

If journey was **curtailed** please provide details of additional travel and sundry expenses including how these were incurred:

PLEASE NOTE 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

ACCESS TO MEDICAL REPORTS ACT 1988

Before your attending doctor can give 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 part 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 he considers 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 Aviva 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 Aviva.

   ☐ I **DO NOT** wish to see the report before it is sent to Aviva.
3. I authorise such Doctor to disclose such information to Aviva.
4. I agree that a copy of this consent shall have the validity of the original.

_____ 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: _____

Postcode: _____

Bank Sort Code: | | | | | | |

Account Number: _____

Name of Account Holder(s): _____

DATA PROTECTION

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

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

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

USE OFFICIAL STAMP

SIGNED _____ DATE _____

CHECKLIST

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
- ☐ Your attending physician has completed and signed where applicable

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