Mapfre Assistance Agency Ireland Claims
Ireland Assist House,
22-26 Prospect Hill,
Galway, Ireland
traveldept@mapfre.com

CANCELLATION CLAIM FORM

	Claim Reference Number:
	Policy Number:

Thank you for your recent claim notification. Please ensure you read the below instructions carefully for returning the claim form and supporting documentation.

Claim form and supporting documentation:

1. Please complete all sections relevant to your claim, sign and date the form. **Please note an incomplete application will delay the processing of the claim.**

2. You must return this form to the postal address listed above and attach the following documentation:

   ☐Booking Invoice showing breakdown of travel and accommodation costs including booking T&C's

   ☐Certificate of insurance (Photocopy only)

   ☐ Medical Certificate completed in full by the usual treating GP of the person whose condition gives rise to the claim. In addition, should the circumstances have necessitated referral to a consultant or hospital please provide the documentation for same.

   ☐Death Certificate (if applicable). (This will be returned on completion of claim)

   ☐Cancellation Invoice(s) showing full cancellation charges for Flights and Accommodation.
   (Please obtain from the Tour Operator where appropriate).

   As the circumstance of each claim differs, on receipt of your claim form, it may be necessary for us to request additional information not outlined in the checklist above. **Failure to provide the above documentation may delay the processing of your claim.**

3. You must as part of the policy terms and conditions declare if you have any other insurance in force at the time of your claim (this includes any insurance which may have been provided in association with your bank account).

If you have any queries or require assistance in completing the claim form please do not hesitate to contact us. Please have your claim reference number to hand.

Yours sincerely,

For and on behalf of
Mapfre Assistance Agency Ireland Claims

Mapfre Assistance Agency Ireland Claims
Ireland Assist House, 22-26 Prospect Hill, Galway, Ireland
traveldept@mapfre.com

CANCELLATION CLAIM FORM

Claim Reference Number:	(Please see first page of claim form for your reference)
Policy Number:	(Please see first page of claim form for your policy number)

DATA PROTECTION

We will ask you to provide some specific information regarding the medical condition or injury giving rise to your claim, and also regarding current or past medical conditions for you and, where relevant, for your fellow travellers, close relatives or close business associate. We will only use sensitive information for the specific purpose you provide it, including to validate and administer your claim, and to provide the services described in the policy. This may include sharing with service providers, and if you have travelled outside the European Economic Area 'EEA', it may be necessary for us to transfer your data and share with service providers outside the EEA. Further information about how data is used and shared can be found in our privacy policy on www.mapfreassistance.ie/gdpr.
You must ensure that you only provide sensitive information about other people where you have the consent or legal right to do so.

SECTION A

CLAIMANT DETAILS

Title:		Gender:	
Forename:		Surname:	
Date of Birth:		Occupation:	
Address:		Home Phone Number:	
		Work Phone Number:	
		Mobile Number:	
		Email Address:	

TRIP DETAILS

Tour operator:		Booking agent:	
Destination:		Date trip booked:	
Departure date:		Return date:	

SECTION B

ANY OTHER INSURANCE DETAILS:

Travel Insurance policy? YES ☐ NO☐
Insurance with your bank account / bank card? YES ☐ NO☐
Any other insurance policy which may cover this loss? YES ☐ NO☐
If Yes to any of the above, please provide Company Name & Policy Number: _____

PREVIOUS CLAIMS HISTORY:

Have you made ANY insurance claim in the past 3 years? (If yes, please provide details below) YES/NO

Year	Type Of Claim	Amount Claimed	Company

DECLARATION: Insurers and their agents share information to prevent fraud and for underwriting purposes. This document, information provided when taking out the Policy and relevant facts form the basis of your claim and may be shared or used for audit purposes. It is a criminal offence to make a fraudulent claim. We investigate all cases and any person suspected of fraud is reported to the Police/Gardai with whom we always cooperate in effecting a prosecution. I/We understand that you may seek information from other insurers and third parties to check that the information provided above is truthful and that details of this claim can be used for audit and fraud prevention purposes. I/We understand that you may request information from medical

providers abroad in relation to a claim where medical advice was sought. I/We declare that to the best of my/our knowledge and belief that all the information I/We have given is correct. I/We have not withheld any information connected with this incident and agree to provide any further information or documentation as may be required. I understand that the insurer does not admit liability by the issue of this form.

ALL PERSONS CLAIMING MUST SIGN BELOW:

Name (please print)	Signature	Date

SECTION C

INCIDENT DETAILS

Please detail the medical condition / injury giving rise to your claim:

_____

_____

Date symptoms first began / injury occurred	
Date first consulted a Medical Practitioner	
Date Medical Practitioner recommended cancellation	
Date cancellation was notified to Travel Agent / Tour Operator	

We may need to contact the Medical Practitioner if any point needs clarification. In order for us to do so, please give us your authority by signing below:

Signed:_____

Medical Practitioner's contact details:_____

Did you make a medical declaration prior to Booking your Trip/Purchasing your Insurance: YES/NO

If 'Yes', please provide reference number: _____

Please list all persons claiming and their relationship to the lead insured:

Name	Relationship	Age		Name	Relationship	Age

CANCELLATION EXPENSES CLAIMED

Date Expense Incurred	Description	Amount Paid	Refund Amount	Claimed Amount	Office Use Only

Total holiday cost paid (excluding insurance premium)	
Total amount refunded / pending to be received	
Amount claimed (less any refunds received / pending)	

SECTION D

(NB Payment cannot be issued unless all below details are provided)

Bank Name and Branch:_____

Account Holder's Name:_____ Account Number:_____

Sort code:_____ IBAN Number:_____

MEDICAL CERTIFICATE

To be completed by the USUAL MEDICAL PRACTITIONER of the person whose illness/injury/death gives rise to the claim. Any charges incurred for the completion of this certificate are NOT refundable under the terms of the insurance policy. This information will be treated as private and confidential.

Notice to claimant: Please complete section 1, 2 & 3 prior to giving to the Medical Practitioner for completion

1. Date trip booked:	2. Date insurance purchased:	3. Travel dates:

Notice to Medical Practitioner: Please complete all sections as it may result in the document being returned if all details are not provided. You must ensure that you only provide sensitive information about other people where you have the consent or the legal right to do so.

Name of person to whom this certificate applies:	D.O.B
Are you his/her usual treating GP?	If YES, for how long?
Please describe the MEDICAL CONDITION / INJURY which gives rise to this claim:	
What date did the patient first consult for this condition (please specify the exact date)?	
Was the patient examined by you (or a colleague) in the clinic on the above date?	
How long were the symptoms in existence prior to consulting on the above date?	
What date did you recommend cancellation of the holiday?	
Has the patient been referred to a Consultant/Specialist/Hospitalised in the last 2 years? If YES, outline the condition(s), date(s) of referral(s) & type of treatment/ investigation:	
Was the patient on a waiting list/awaiting results for any tests/treatments or consultation(s) at the time of inception of the insurance / booking trip? (Please refer to the top of this certificate for the dates) If YES, please provide details (including condition & dates of referrals):	
Has the patient received a terminal prognosis?	If YES, what date was this given?

Please provide details of all consultations in the previous 2 years:

Date of Consultation	Reason for Consultation	Medication Prescribed

Declaration

I certify that the reason for this claim was due only to the medical reasons stated above and, in the case of a claim for cancellation, that cancellation was medically necessary. I confirm that I have obtained the explicit consent of the data subject to share this information for the purposes of validating and administering the claim.

Doctor's Name (please print) _____ Doctor's Official Stamp:

Signature: _____

Date: _____