CANCELLATION CLAIM FORM
(trip cancelled by you)

Date sent to us _____ Claim reference number (if known) _____

Please answer all relevant questions on the claim form. Leaving items blank, using ticks, dashes and n/a may result in us returning the claim form and/or asking further questions, thus delaying the processing of your claim.

Hollard Travel Insurance is underwritten by The Hollard Insurance Company Limited (Hollard), a registered short-term insurer and an authorised financial services provider, and managed by Oojah Travel Protection (Pty) Ltd.

Please send your completed claim form and all supporting documentation to: Oojah Travel Protection, Fax No: 0866 43 44 36 or claims@hollardti.co.za. For assistance you may contact them on +27 11 351 4531.

CLAIMANT DETAILS

Title	Mr ☐ Mrs ☐ Miss ☐ Ms ☐ Other	Country of residence	
Surname		Nationality	
First name		Postal address	
Date of birth			
Home telephone		Postal code	
Work telephone		ID number	
Mobile telephone		Date of booking (trip)	
E-mail		Departure date	
Policy number		Return date	
Date policy purchased		Number in party	

Credit card number used to purchase tickets _____

Do you or anyone else claiming have any other insurance which may cover the claim, e.g. airline, medical aid, bank/credit card insurance YES ☐ NO ☐

If YES, please provide details below

Company name _____ Policy number _____

Have you or any person claiming under this policy made any previous claims on this type of insurance YES ☐ NO ☐

If YES, please provide details _____

DECLARATION and AUTHORITY

1. I/We hereby declare that all information, answers, and documentation given in connection with this claim are **true and correct** to the best of my/our knowledge and belief. I/We have not omitted any material information, which could affect the underwriter's judgement of the claim.
2. I/We understand that the information on this form will be passed to or used by us and our appointed claims handling agent, this includes underwriting, processing, handling claims and preventing fraud.
3. I/We **authorise any doctor, hospital or other organisation or person having any records or information concerning my medical history or treatment** to furnish such records of information as may be requested by us or our claims handling agent. I am also aware that such information/records are relevant in the evaluation of my claim and that non-submission could prejudice my claim. A photocopy of this authorisation shall be considered as effective and valid as the original.
4. I/We further declare that I am/We are aware that any **misrepresentation and/or non-disclosure** in respect of information provided herein shall render my/our claim null and void.
5. I/We declare that I/We have read **the policy wording**.

I have read and fully understand the declaration above (ALL persons claiming must sign)

Insured Person's Name and Surname	**Date of Birth**	**Signature**

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Documents You need to send to Us – SEND COPIES OF DOCUMENTS AND KEEP ORIGINAL DOCUMENTS FOR YOUR RECORDS

1. **Itinerary**: original travel tickets for your booked itinerary (including tickets from/back to South Africa).
2. The original holiday/flight invoice (original amount paid and any refund amount due).
3. A letter from the provider confirming their cancellation/refund policy and whether any amount was refunded to you.
4. If cancellation is on **medical grounds**, including **death**, the medical history must be completed by the usual medical practitioner of the individual whose condition has led to the submission of the claim (refer to the Medical Section).
5. If cancellation is due to **death** we require a certified copy of the death certificate.
6. If this claim is being submitted as a result of an **injury** please provide a full description of the incident leading to the injury. If a third party was involved please provide their details.
7. If cancellation is due to **redundancy** we require a letter from your former employer which confirms that you have been made redundant and are due to receive a payment under current legislation, the position you held and your length of service.

INSURED REASON FOR CLAIM (please select one box only)

Death ☐	Unexpected injury ☐	Unexpected illness ☐	Redundancy ☐
Damage to home ☐	Flight delay 12hrs+ ☐	Compulsory quarantine ☐	Terrorist incident ☐

Cancellation for any reason not listed above (Comprehensive Cover only)

Date policy purchased _____ Date you paid for your trip _____

Please answer ALL questions – BLOCK CAPITALS PLEASE

Date you became aware of the need to cancel your trip? _____

Date you informed the airline, accommodation provider, travel agent or tour operator of the need to cancel your trip? _____

The name of the person who has caused the cancellation and their relationship to you?

Name _____

Relationship _____

At the time of purchase of the policy or booking the trip, were you aware of any reason why the trip may need to be cancelled? YES ☐ NO ☐

DETAILS OF TRIP COSTS AND CANCELLATION CHARGES

Important: You must obtain a letter confirming the refund policy (even if no refund due) prior to submitting your claim to us.

Ref	Date	Description of item	Currency	Amount paid	Amount refunded	Office use

Total claimed _____

NAMES AND DATES OF BIRTH OF THOSE CANCELLLING

Name	Date of birth

Please provide a detailed description as to the reason for cancellation (ticked above)

Important Notes:

- A policy excess is applicable in respect of all claims.
- A flight/trip cancelled by the provider is not covered by your policy. You should direct your claim to the provider involved.

ALL CLAIMS RELATING TO ILLNESS (including death)

To be completed by the person that is the cause of the claim's regular treating doctor.

Please note that this information will be treated as confidential and will only be used to assess the travel insurance claim. We hereby confirm that this information is pivotal to the claim as no authorisations for payment can be issued until this report has been inspected by our own independent medical advisor.

1. Name and Surname (of the person that was the cause of the claim)
2. Date of departure
3. Regular doctor's name and surname
4. Doctor's PR number
5. Patient's medical aid number
6. Diagnosis (reason for the claim)
7. Date of Diagnosis
8. Date of first consultation relating to the condition
9. In your opinion, does the diagnosis relate directly or indirectly to a pre-existing medical condition for which the patient received either treatment or advice? YES ☐ NO ☐
10. List of chronic medications – prior to the date of departure

Condition	Date of diagnosis	Name of medication

11. List of prescribed medication – prior to date of departure (if different from chronic)

Condition	Date of diagnosis	Name of medication

12. Date and reason for last 5 consultations (prior to date of departure)

Date	Details

13. Date and details of most recent surgical procedures

Date	Details

Doctor's signature

Medical practice stamp and date completed: