22-26 Prospect Hill
Galway, Ireland
traveldept@mafpre.com

TRAVEL INSURANCE CLAIM FORM

	Claim Reference Number:
	Policy Number:

PLEASE COMPLETE ALL SECTIONS IN BLOCK CAPITALS

CLAIMANT DETAILS

NAME OF LEAD CLAIMANT: Title: ____ Forename: _____ Surname: _____

Sex: M/F D.O.B. _____ Occupation: _____

ADDRESS: _____

_____ POSTCODE: _____

TELEPHONE NO: Home _____ Work _____

LEAD POLICYHOLDER NAME: Title: ____ Forename: _____ Surname: _____

Claimant's Relationship to Lead Policyholder: _____

HOLIDAY/TRIP DETAILS

Tour Operator: _____ Travel Agent: _____

Destination/Country: _____

Date holiday booked: _____

Departure Date: _____ Return Date: _____

PREVIOUS CLAIM DETAILS:

Have you made an insurance claim in the past 5 years? **YES/NO**

If YES please provide details:

Date	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 to check that the information provided above is truthful and that details of this claim can be used for audit 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

DELAYED/MISSED DEPARTURE/ABANDONMENT–

CLAIM DETAILS:

Is this claim for: Travel Delay Benefit ____ Missed Flight ____ Abandonment _____

Due Check-In Date: _____ Time:_____ Actual Check-In Date: _____ Time: _____

Due Departure Date: _____ Time:_____ Actual Departure Date: _____ Time:_____

Please detail the circumstances giving rise to this claim: _____

_____

_____

_____

_____

_____

Duration of Delay (in hours): _____

If trip was abandoned, please provide date and time decision was made: Date: _____ Time: _____

Total number of insured claimants: _____

Please provide details of all persons claiming who are insured by the policy:

Name	Age	Name	Age

AMOUNT CLAIMED:

Travel Delay Benefit Only:

Benefit Applicable _____ X _____ (number of claimants) = Total Claimed _____

Missed Departure Claims Only: (Please continue on a separate sheet using the same format if necessary)

Date Expense Incurred	Description	Foreign Currency Amount	Rate of Exchange	Bill Paid - Yes/No	Office Use Only

CHECKLIST: Please ensure you sign the declaration overleaf and enclose the following ORIGINAL documents as applicable:

Booking Invoice / Travel Tickets showing full holiday details YES/NO

Certificate of Insurance (Photocopy only) YES/NO

Written Confirmation from the Carrier (or their agents) confirming reason and exact duration of delay YES/NO

Proof of Abandonment (i.e. original tickets (if issued) / cancellation invoice, etc.) (if applicable) YES/NO

Report from the garage confirming details of a breakdown of a private vehicle YES/NO

Payment Details (Please tick the appropriate form of payment):

Cheque:_____ Bank Transfer:_____

If you wish to receive payment by bank transfer, please supply us with the following information;

Bank Name and Branch:_____

Account Holder's Name:_____ Account Number:_____

Sort code:_____ IBAN Number:_____