

Covid-19 Cancellation Expenses Claim Form



Please complete this claim fully and return to us by following the postal instructions below.

Please return your completed form to:
P.O.BOX 133 PATTAYA POST OFFICE
SOI PASSANI NONG PRUE
BANGLAMUNG THAILAND 20260

or print out, fill in, scan and email to:
claims@thailandcovidinsurnance.com

Personal details

Title	Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms <input type="checkbox"/>	Other	<input type="text"/>	
Family name	<input type="text"/>		First name	<input type="text"/>
Date of birth	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Address	<input type="text"/>			
	<input type="text"/>			
	<input type="text"/>		Post code	<input type="text"/>
Daytime tel no.	<input type="text"/>		Evening tel no.	<input type="text"/>
Email address	<input type="text"/>		Occupation	<input type="text"/>

Policy details

Company name	<input type="text"/>			If applicable
Policy number	<input type="text"/>		Date of issue	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Date of booking	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Destination	<input type="text"/>
Date of travel	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		Date of return	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Travel agent	<input type="text"/>		Tour operator	<input type="text"/>

Claim details

Reason for cancellation

Names of all persons cancelling

Date travel agent or tour operator advised of cancellation

Verbally

In writing

If cancellation was due to a person not booked to travel please state:

Full name

Relationship

Cancellation charges and payment information

Total paid to travel agent / tour operator	\$	Payment method	
Cancellation charges applied	\$	Refund given	\$
Total amount claimed	\$		

Information we need from you for possible recovery opportunities

Your Travel Policy has conditions attached whereby you must provide us with any information that assist any recovery actions. This is a standard practice in the insurance market and contributions made from other insurance cover serve to keep the costs of your premiums down. The information provided should not affect your renewal premiums or no claims discount.

Please answer the following questions and provide details as required. For questions that require a YES / NO response, please tick the appropriate boxes. Failure to do so may delay your claim.

1. Do you have a bank account?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
A bank account you hold may offer Travel Insurance cover as part of the benefits. Under no circumstances will your bank account information be used other than to obtain a contribution from the Travel Insurance provider. This will not affect your bank account in any way.				
	Name of bank (e.g. HSBC)	Type of account	Account holder name	Account number
Bank Account				

2. Was a credit card or debit card used to pay all or part of the trip cost? (Certain credit or debit cards provide an element of travel cover)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Card issuer	Type of card e.g. Visa	Cardholder name	Card number
Bank Account				

3. Do you have a Household Contents insurance policy? (Some household contents policies provide an element of travel cover)		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Name of Insurer	Policyholder name	Policy number	
Bank Account				

4. Do you hold any Private Medical Insurance?		Yes <input type="checkbox"/>	No <input type="checkbox"/>	
	Name of Insurer	Policyholder name	Policy number	
Bank Account				

5. Do you consider anyone to blame for the incident?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<p>If yes, please provide details.</p>		

It is a condition of the policy and your responsibility to provide sufficient documentation to support your loss. Failure to provide the required documentation, including the details of any other insurances, will delay and may invalidate the claim.

Access to Medical Reports 1988

It may be necessary to apply for a medical report from a Doctor who has cared for you, and we ask that you give your consent by signing the claim form declaration. Before doing so, however, you should read this note carefully, as it sets out your rights under the Access to Medical Reports Act 1988, and the procedures for dealing with the reports. You do not have to give your consent, but if you do, you can say whether you wish to see the report (or have a copy of it) before it is sent to us. If you say you wish to see the report, we must tell you at the same time as we write to the Doctor and we must tell him / her you wish to see the report. You have 21 days to contact the Doctor about arrangements for you to see the report.

Whether or not you say you wish to see the report before it is sent to us, the Doctor must let you see a copy for up to six months after it is supplied (if you ask). If you ask the Doctor for a copy of the report, he can charge you a reasonable fee to cover his / her costs.

Once you have seen a report, before it is sent to us, the Doctor cannot submit it until he has your written consent. You can write to the Doctor asking him to amend any part of the report which you consider to be incorrect or misleading, and have attached to the report a statement of your view on any part which he will not amend.

The Doctor is not obliged to let you see any part of a report if, in his opinion, that would be likely to cause serious harm to your physical or mental health or that of others, or would indicate the Doctors intentions towards you or if disclosure would likely to reveal information about you or the identity of another person who has supplied information about you, unless that person has consented to the information relates to, or has been supplied by a health professional involvement in caring for you. In such cases, the Doctor must notify you in writing and you will be limited to seeing any remaining part of the report. If it is the whole of the report that is affected, he / she must not send it to us unless you give your written consent.

Medical certificate

If your holiday / journey has been cancelled due to illness or injury this form must be completed by the usual medical practitioner of the ill / injured /deceased person (if applicable).

Please continue on a separate piece of paper if necessary. This information will be treated as PRIVATE AND CONFIDENTIAL. All other certificates are unacceptable. This form must be provided at the expense of the claimant. If a MEDICAL SELF DECLARATION was completed please provide details.

1.	Patient name	
2.	Patient age	
3.	Please confirm the exact nature of the illness / injury or cause of death which makes cancellation of this trip medically necessary and / or prevents travel.	
4.	Date on which you were first consulted re. 3 above. Were you aware of their proposed trip at this date?	
5.	Has the Patient received a terminal prognosis?	
6.	Has the patient suffered from the same or similar condition in the past? If YES, is the present illness, in your opinion, resulted in any way to the past condition?	
7.	<ul style="list-style-type: none"> a. Please give dates and details of any in-patient treatment. b. Date place on waiting list. c. Nature of investigation or surgery d. Date of hospital admissions. 	
8.	If cancellation due to pregnancy please give: <ul style="list-style-type: none"> a. Date of confinement b. Date of pregnancy confirmed c. Details of illness / injury connected with the pregnancy which gave rise to your recommendation not to travel. 	
9.	<ul style="list-style-type: none"> a. Give details of any condition(s) which have been / are under supervision of a hospital /consultant / doctor or has required hospital admission or treatment in the previous 2 years. b. Give details if the Patient is / was suffering from any chronic disease, illness or from any physical defect or infirmity, including cancerous cardio-vascular, cerebro-vascular, renal, psychiatric or mental condition. c. Give details of any of the conditions advised in (a) and / or (b) which may have a bearing on the conditions(s) described in question 3. d. Give details if the Patient is / was awaiting result of any tests, investigations or if the person is on a waiting-list for any in or out-patient treatment or investigation. e. Give details of any continuous medication or changed medication or dosage increase resulting in a deterioration in the condition in the previous 2 years. 	
10.	Date on which cancellation could have been anticipated.	
11.	Date on which you advised the holiday should be cancelled.	
12.	In your opinion, was cancellation medically necessary? If YES, was it solely due to the above condition? In your opinion when will the patient be fit for normal overseas travel?	
13.	Please confirm that your patient was fit to travel at the time the insurance was issued.	
14.	General remarks. (Please comment on the reason for not travelling if applicable).	
<p>DOCTORS DECLARATION : I declare that I have examined the patient named above and / or have referred to their medical records and confirm that the information given above is a true and accurate statement, and further that no material information has been withheld.</p>		This section to be validated by surgery's stamp
Print name		Signed
		Date

Claimants declaration and signature

1. I declare that all details and particulars given in respect of the claim(s) made herein constitute a true and accurate statement.
2. To the best of my knowledge and belief I have not omitted any material information which would affect the insurers assessment of this claim.
3. I confirm that where a claim or claims are made in respect of others, I have their full authority to act on their behalf. I also confirm that they have been advised that Thailand Covid 19 Insurance LLC will not accept any liability if any payments are not distributed proportionately to the persons concerned.
4. I hereby give my permission for any medical practitioner or authority mentioned herein to release further information regarding my medical records to TCI. I am aware that all such information will be disclosed in accordance with the terms and provisions of the Access to Medical Records Act (AMRA) or other similar legislation.
5. I am aware that an insurance claim made in the knowledge that any element thereof is fraudulent is a criminal offence and that this will invalidate the policy and will render me liable to prosecution.
6. I consent to TCI:
 - a. recording, storing and using my personal data in an electronic record of this claim; and
 - b. sharing the record of this claim, including my personal data, with other insurers and interested parties as part of insurance industry anti-fraud initiatives; in accordance with the General Data Protection Regulation.

I have read and understand the declaration above and included the necessary documents to substantiate my claim.

Claimant(s) full name(s)	<input style="width: 100%;" type="text"/>		
Clients signature	<input style="width: 300px; height: 40px;" type="text"/>	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

Full name of an authorised representative of the corporate policy holder (corporate and / or education group cover)

<input style="width: 100%;" type="text"/>			
Signature of authorised representative	<input style="width: 300px; height: 40px;" type="text"/>	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

I / We authorise	<input style="width: 300px; height: 20px;" type="text"/>	to act on my behalf in this matter.
Client's signature	<input style="width: 300px; height: 40px;" type="text"/>	Date
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

Confidentiality and data protection

Consent

We will only use Your personal data when the law allows Us to. Most commonly We will use Your personal data under the following two circumstances:

1. When You gave explicit Consent for Your personal data, and that of others insured under Your Policy, to be collected and processed by Us in accordance with this Data Protection Notice.
2. Where We need to perform the contract which We are about to enter into, or have entered into with You.

How We use Your Personal Data

We use Your personal data for the purposes of providing You with insurance, handling claims and providing other services under Your Policy and any other related purposes (this may include underwriting decisions made via automated means). We also use Your personal data to offer renewal of Your Policy, for research or statistical purposes and to provide You with information, products or services that You request from Us or which We feel may interest You. We will also use Your personal data to safeguard against fraud and money laundering and to meet Our general legal or regulatory obligations.

We collect and process Your personal data in line with the General Data Protection Regulation and all other applicable Data Protection legislation. The Data Controller is TCI. For the purposes of handling claims the Data Processor is TCI.

Special Categories of Personal Data

Some of the personal data You provide to Us may be more sensitive in nature and is treated as a Special Category of personal data. This could be information relating to health or criminal convictions, and may be required by Us for the specific purposes of underwriting or as part of the claims handling process. The provision of such data is conditional for Us to be able to provide insurance or manage a claim. Such data will only be used for the specific purposes as set out in this notice.

Sharing Your Personal Data

We will keep any information You have provided to Us confidential.

We will share Your information if We are required to do so by law, if We are authorised to do so by You, where We need to share this information to prevent fraud.

We may transfer Your personal data outside of the European Economic Area ("EEA"). Where We transfer Your personal data outside of the EEA, We will ensure that it is treated securely and in accordance with all applicable Data Protection legislation.

Your Rights

You have the right to ask Us not to process Your personal data for marketing purposes, to see a copy of the personal information We hold about You, to have Your personal data deleted (subject to certain exemptions), to have any inaccurate or misleading data corrected or deleted, to ask Us to provide a copy of Your personal data to any controller and to lodge a complaint with the local data protection authority.

The above rights apply whether We hold Your personal data on paper or in electronic form.

Your personal data will not be kept for longer than is necessary. In most cases this will be for a period of seven years following the expiry of the insurance contract, or Our business relationship with You, unless We are required to retain the data for a longer period due to business, legal or regulatory requirements.

Further Information

Any queries relating to how We process Your personal data or requests relating to Your Personal Data Rights should be directed to:

P.O.BOX 133 PATTAYA POST OFFICE
SOI PASSANI NONG PRUE
BANGLAMUNG THAILAND 20260

Tel: +1 806 5764165

Email: claims@thailandcovidinsurance.com

Settlement by BACS

For your convenience and to offer an efficient smoother service, we would like to pay any claim settlement due directly into your bank account. Please provide ALL your details on this form as requested below, remembering to sign and date also.

If you do not wish to provide your bank details, any settlement due on your claim will be issued by cheque and may take a little longer to process.

You will receive an email from us to confirm when this payment has been made.

Your details	
Name of Claimant	
Email Address Where we will send confirmation of payment	

Bank account details	
Name of Payee This should be the same as held on the bank account	
Bank Name	
Bank Address inc. Country and Postcode	
Bank Account Number	
Sort Code	

If your bank account is held abroad, please also enter the following details:	
IBAN/BIC number	
Swift Code	

Signed

Date

IMPORTANT: We do not accept liability for any errors due to the incorrect bank details being provided by you.

PLEASE CHECK ALL DETAILS PRIOR TO SUBMITTING YOUR CLAIM.