eClaim form

#### Travel



**Any cheque in settlement will be made payable to the insured or the school named on the certificate, unless written authority to the contrary is received**

###### Please answer every question

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| --- | --- | --- | --- | --- | --- | --- |
| **1. Insured** | Your reference |  | | Zurich Claim Number | |  |
| Name of Insured/School |  | | Policy/Certificate number | |  | |
| Name of Educational establishment if different from above | | |  | | | |
| Department |  | | | | | |
| Name of party leader (if applicable) | |  | | | | |

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| **2. Claim Details** | | | | |
| Name of person(s) suffering the loss  (if applicable) |  | | Telephone Number |  |
| Address of person suffering the loss  (if applicable) |  | | | |
| Under which section of the policy is the claim being made? | |  | | |
| Approximate date when premium was paid |  | | | |
| Planned departure date |  | | Planned Return date |  |

###### Please fully complete the relevant section(s) below

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| 1. **Cancellation and other expenses** | |
| What was the cause of the loss |  |
| Explain clearly and fully why the loss or additional expenses were inccurred |  |
| What attempt has been made to recover the loss from other sources? (this question must be answered) |  |
| Documentary evidence of the amount of the loss should be attached.  N.B If the loss was due to injury or illness, a doctor’s note should also be attached | |

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| **4. Medical and associated expenses or personal accident** | | | | | |
| Date sustained/incurred |  | Amount of claim | |  | |
| Explain clearly and fully the nature and cause of the injury or illness | |  | | | |
| Provide details of what hospital/medical treatment was administered and the name/address of the hospital/doctor | |  | | | |
| Provide details of additional accomodation or transport costs | |  | | | |
| All medical bills and documentary evidence of other expenses, should be attached | | | | | |
| Zurich Claim Number | |  |

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| **5. Personal accident** | | | Zurich Claim Number | |  |
| Date injury sustained |  | Amount of Claim | |  | |
| Explain clearly and fully the nature and cause of the injury or illness | |  | | | |
| Provide details of what hospital/medical treatment was administered and the name/address of both the treating hospital/doctor, plus the hospital/doctor where further consultation has taken place at home. | |  | | | |
| Provide details of disablement suffered, and the period of incapacity | |  | | | |
| A doctors note should be attached. If we require further medical evidence, we will ask you to complete a mandate | | | | | |

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| **6. Personal effects and money** | | | | | | | |
| Damage/loss/incident | Date | |  | Time |  | Amount of Claim |  |
| Explain clearly and fully the nature and cause of the damage or loss | | | | | |  | |
| Was there any other insurance in force which may cover the damage or loss?e.g household ‘all risks’ insurance. If so, give full details of insurer | | | | | |  | |
| **Items lost/damaged (submit original invoices if possible)** | | | | | | | |
| Item (description) | | Date of original purchase | | | | price | Amount claimed after deduction for wear and tear |
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| 1. **Legal Liability** |

For any event that might give rise to a claim, please write to us stating full circumstances, including date, time,place,Parties involved, and details of damage/injury.

Please also send any correspondance to/from the person/organisation making the claim against you.

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| 1. **Police notification** | | | | | | |
| If items were lost/stolen, please advise date/time notified to police | | | Date |  | Time |  |
| Name of police station |  | | | | | |
| Address |  | | | | Postcode |  |
| Crime report reference number | |  | | | | |
| If not reported to police, state reason | |  | | | | |
| Please attach any report issued by the police | | | | | | |

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| 1. **Any additional information which may be relevant and declaration -** By submitting this completed form I declare that all answers are true and correct to the best of my knowledge and belief | | | | | | | | | | | |
| Customer Specific Data **(For Customer use only)** | | **I.** | | | **II.** | | | | **III.** | | |
| Additional Information |  | | | | | | | | | | |
| By submitting this completed form I declare that all the answers are true and correct | | | | | | | | Date | | |  |
| Contact name |  | | Job Title | | |  | | | | | |
| Postcode |  | | Email Address | | |  | | | | | |
| Phone number |  | | Are you VAT Registered? | | | |  | | | | |
| What percentage recovery can you make for customs and excise? | | | |  | | | | | | | |
| Zurich Claim Number | | | |  | |