



DAMAGE OR INJURY TO A THIRD PARTY FOR WHICH YOU ARE LEGALLY LIABLE



Claims Dept
PO Box 420
Hadlow
Kent
TN9 9DE

Tel: 0845 370 7187
Fax: 0870 620 5001
Web: www.tif-plc.co.uk

Dear Customer,

In order that we can process your claim quickly, please complete all relevant sections of the claim form, giving as much detail as you can and **return it to us at the above address**, together with the following **ORIGINAL** documentation. Please note that in the interest of protecting ourselves from fraud we are unable to accept photocopied receipts or invoices.

We recommend that you keep your own copy of all documents forwarded to us.

To help you enclose the correct paperwork to support your claim we have put together a checklist. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

CHECKLIST OF DOCUMENTS REQUIRED

ALL CLAIMS

- DOCUMENTATION SHOWING YOUR TRAVEL DATES AND FULL COST OF THE TRIP (booking invoice)
- PROOF OF INSURANCE (i.e. certificate/schedule or confirmation email). As claims handlers we do not hold this information
- WRITTEN REPORT FROM THE POLICE OR THE TOUR OPERATORS REPRESENTATIVE
- WRITTEN REPORTS FROM ANY THIRD PARTIES OR WITNESSES OF THE INCIDENT
- ALL** CORRESPONDENCE RELATING TO THE INCIDENT (preferably unanswered)

IF YOU HAVE PAID ANY SUMS FOR REPAIRS FOR DAMAGE CAUSED

- ORIGINAL INVOICES FOR ANY REPAIR OR REPLACEMENT ALREADY CARRIED OUT
- RECEIPTS FOR ANY PAYMENTS YOU HAVE ALREADY MADE

IF THIS IS A WINTER SPORTS CLAIM

- FULL DETAILS OF WITNESSES
- WRITTEN REPORT OF INCIDENT FROM PISTE REPRESENTATIVE OR RESORT REPRESENTATIVE
- WRITTEN MEDICAL REPORTS FOR ANY INJURED PERSONS

You should note that all the information provided to us on this form will be stored electronically in accordance with The Data Protection Act and shared with the Insurance Industry Fraud Prevention Unit. If you make a fraudulent or intentionally exaggerated claim this will invalidate your claim and we will pursue a recovery through the civil courts in all cases.

We do understand that it may take time to collect all the documentation required but please try to submit your claim as soon as possible after the event.

Yours faithfully

Travel Claims Facilities

CLAIM FOR PERSONAL LIABILITY – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

TO BE COMPLETED BY THE CLAIMANT – the person who caused the damage

Title:	<input type="text"/>		
First Name:	<input type="text"/>	Surname:	<input type="text"/>
Address:	<input type="text"/>		
Post Code:	<input type="text"/>		
Telephone:	<input type="text"/>	Date of Birth:	<input type="text" value="DD / MM / YY"/>
Email:	<input type="text"/>		

DETAILS OF THE INSURANCE POLICY

Where / who did buy your insurance from:	<input type="text"/>		
Policy name:	<input type="text"/>	Date Policy Issued:	<input type="text" value="DD / MM / YY"/>
Policy number:	<input type="text"/>	Master Policy Number:	<input type="text"/>
<small>Found on Schedule, Certificate, or Booking Invoice</small>		<small>Found on policy wording (ABCDE400...)</small>	
Destination:	<input type="text"/>	<small>i.e. Europe / Worldwide</small>	

DETAILS OF TRIP

Travel Agent / Tour Operator:	<input type="text"/>		
Date Trip Booked:	<input type="text" value="DD / MM / YY"/>	Date final balance paid:	<input type="text" value="DD / MM / YY"/>
Method of payment (cash, cheque, debit card, credit card):	<input type="text"/>		
Please confirm your original travel dates:	From:	<input type="text" value="DD / MM / YY"/>	To: <input type="text" value="DD / MM / YY"/>

DETAILS OF CLAIM

Date incident happened:	<input type="text" value="DD / MM / YY"/>	Time of Incident:	<input type="text" value="HH / MM"/>
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Please describe in detail the circumstances leading up to this claim. Please try to include dates and times. You should give as much information as possible and the reason why you feel you are or are not liable for this incident (please continue on the reverse should you need further space):

CLAIM FOR PERSONAL LIABILITY – Claim Reference Number: TBA

Please complete all sections of this form and check the list of additional documents you need to send in order that we can assess your claim. Please ensure you read this carefully as failure to supply the correct documents may delay our assessment of your claim.

THIRD PARTIES INVOLVED

Name:	<input type="text" value="Please print"/>	Name:	<input type="text"/>
Address:	<input type="text"/>	Address:	<input type="text"/>
Post Code:	<input type="text"/>	Post Code:	<input type="text"/>
Telephone:	<input type="text"/>	Telephone:	<input type="text"/>
Email:	<input type="text"/>	Email:	<input type="text"/>

WITNESSES

Name:	<input type="text" value="Please print"/>	Name:	<input type="text" value="Please print"/>
Address:	<input type="text"/>	Address:	<input type="text"/>
Post Code:	<input type="text"/>	Post Code:	<input type="text"/>
Telephone:	<input type="text"/>	Telephone:	<input type="text"/>
Email:	<input type="text"/>	Email:	<input type="text"/>

Name:	<input type="text" value="Please print"/>	Name:	<input type="text"/>
Address:	<input type="text"/>	Address:	<input type="text"/>
Post Code:	<input type="text"/>	Post Code:	<input type="text"/>
Telephone:	<input type="text"/>	Telephone:	<input type="text"/>
Email:	<input type="text"/>	Email:	<input type="text"/>

DETAILS OF YOUR HOME INSURANCE (CONTENTS AND PERSONAL POSSESSIONS)

Name of Insurer:	<input type="text"/>	Policy number:	<input type="text"/>
Insurers Address:	<input type="text"/>		
Post Code:	<input type="text"/>		
Will you be making a claim under this policy:	Yes: <input type="checkbox"/>	No: <input type="checkbox"/>	
If YES, please supply the claim reference number:	<input type="text"/>		

CLAIM DECLARATION:

- ✓ I/We declare that all the details provided above are true and accurate to best of my knowledge.
- ✓ I/We give consent for Travel Claims Facilities to seek recovery of monies paid where other insurers cover the same risk, or from third parties who may be held liable.
- ✓ I/We understand that details of this claim may be passed to the insurance industries central claim register
- ✓ I/We understand that if a claim is found to be fraudulent or exaggerated that this will invalidate the whole claim and Travel Claims Facilities may seek to recover any costs through the civil courts.

Once you have read and agreed to the above declarations, please sign and date below.

Signature of patient or **Signature of next of kin** **Date:**

Please print name:

If next of kin, please advise your relationship to the patient:

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 your details on this form, remembering to sign and date below.

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.

YOUR DETAILS

Name of Claimant

BANK ACCOUNT DETAILS

Name of Payee

This should be the same as held on the bank account

Bank Name

Bank Address

Bank Address

Bank Address

Country

Post Code

Bank Account number

Sort Code

If your bank account is held abroad, please also enter the following details:

IBAN / BIC number

Swift code

Signed

Dated

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