U M Association Limited

Cancellation/Curtailment/Rearrangement Claim Form

Thank you for notifying us of your claim
Please complete all questions – if any question is not applicable please state 'N/A'

This form can be completed electronically or by hand. Please send the completed form together with all relevant correspondence to: **U M Association Ltd, 5 St Helen's Place, London EC3A 6AB**
Telephone: 020 7847 8670 Fax: 020 7847 8689 Email: claims@umal.co.uk

Please note: Windows 10 users viewing this form in MS Edge or Mac Users viewing in Preview may encounter problems saving the information entered. To avoid this, please ensure you have downloaded this form and are viewing it in the latest version of Acrobat Reader.

Name of Institution (University, College etc)

Certificate no.

Date on which travel commenced or was due to commence

Date on which travel due to end

Full name of person covered (Mr, Mrs, Miss, Ms)

Date of Birth

Full address including postcode

Telephone no.

Email

	Full name of other persons covered	Date of Birth	Relationship
1			
2			
3			

Please ensure you sign the declaration on the last page of this claim form

Travel Details

Type of travel: Business ☐ Holiday ☐ Placement ☐ Internship ☐

Please give the reason for the cancellation/curtailment/rearrangement of the journey

Please state the scheduled times of travel:

Outward date Return date

Date journey booked Date of cancellation/curtailment/rearrangement

Please provide a copy of your original itinerary/travel documents

If the cancellation/curtailment was due to illness or injury, please state:

a) Name of sick/injured person Age

b) The exact nature of illness/injury and the commencement date

c) Has the person concerned previously suffered the same or a similar complaint? YES ☐ NO ☐

If 'YES', please give the relevant dates

At own cost, please provide medical evidence from the attending doctor or please ask the attending doctor to complete the following:

Nature of complaint preventing travel

Validation Stamp

Date treatment sought

Was cancellation of the journey medically necessary? YES ☐ NO ☐

Signature Date

If journey was **cancelled**, please give details of expenditure incurred:

Total amount paid Total amount refunded Amount to be claimed

Please provide a cancellation invoice together with your travel documents from your tour operator, transporter carrier or accommodation agent.

If journey was **curtailed/rearranged**, please provide details of additional travel and sundry expenses including how these were incurred.

Receipts need to be enclosed for ALL these charges.

Details of Expense

All accounts bills, receipts, medical certificates, booking invoices, any correspondence and any other documents relative to this claim should be forwarded to the company

Claimant name	Date	Nature of expense	Currency of expense	Amount paid	Refund received
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐
					☐

Total £

Please ensure you provide original receipts/invoices for all expenditure

Access To Medical Reports Act 1988

Before a doctor can give a medical report on this claim form, which is a requirement of this claim, the person covered must give their consent.
Before giving consent, they should be aware of their rights under the Act which are summarised as follows:

1. They may withhold their consent.
2. They may see the report before it is sent to us within 21 days from the date of this report.
3. They may ask to see the report for up to six months after the report is completed.
4. They may ask the doctor to amend any part of the report, which they consider to be incorrect or misleading. If the doctor does not agree with this request the person covered may attach their comments to this report.

NB The doctor may withhold all or part of this report from the person covered if he considers that they may be physically or mentally harmed by it.

Patient Declaration

Having been made aware of my statutory rights under the Access to Medical Reports Act 1988 in connection with my claim

1. I hereby consent to UMAL seeking medical information from any doctor who at the time has attended me concerning conditions which affect my physical or mental health.
2. Please tick the appropriate box
   - ☐ I **DO** wish to see the report before it is sent to UMAL
   - ☐ I **DO NOT** wish to see the report before it is sent to UMAL
3. I authorise such doctor to disclose such information to UMAL.
4. I agree that a copy of this consent shall have the validity of the original.
5. I agree that any information obtained by UMAL may also be shared, in confidence, with Tokio Marine Kiln Group Ltd.

Signature	Date

Declaration

This form can be signed using a Digital Signature. Instructions are provided in the signature box below. For further information please click here (https://helpx.adobe.com/acrobat/using/certificate-based-signatures.html).
If you prefer, the form can be signed by hand, scanned and emailed or posted to us.

Name	Signature
Position	
Date	

Please ensure:

- You have completed ALL relevant questions on this claim form.
- You have enclosed ALL requested information/documentation.
- You have signed this claim form.

As failure to do so will result in delay in handling your claim.