

TRAVEL CANCELLATION CLAIM FORM

PRIVACY NOTICE

By completing this form, you will have provided NCBA Insurance Company Limited (NCBA Insurance) with your Personal Data. Personal Data is any information that identifies you or other individuals named in this form. Please note that you should only provide Personal Data about someone else to us with the individual's express permission. NCBA Insurance will, in adherence to the principles of data protection, collect, store, use, transfer (including cross-border), and disclose certain Personal Data in connection with the provision of insurance services. You have a right to be informed of the use to which your Personal Data is to be put; a right to access your Personal Data in our custody and to request us transfer it to another organization; a right to object to the processing of all or part of your Personal Data; a right not to be subject to a decision based solely on automated processing; a right to correction of false or misleading data; and to deletion of false or misleading data about you. Detailed information about how we use Personal Data is set out in our Privacy Policy, which you can find at <https://ke.ncbagroup.com/privacy-policy/>.

SECTION A : PERSONAL DETAILS

First Name: _____ Surname: _____
Date of Birth: _____ Occupation: _____
Nationality: _____ ID Number: _____
Postal Address: _____ Postal Code: _____ Town: _____
E-Mail Address: _____ Mobile Phone: _____

SECTION B : POLICY INFORMATION

Policy Number: _____ Name of policy: _____
Date issued: _____ Policy start date: _____ Policy end date: _____
Date the loss occurred: _____ Number of insured travellers: _____
Please advise the section(s) of the policy you are making the claim under: _____
Total amount claimed: _____

SECTION C : TRAVEL DETAILS

Booking reference: _____ Booking Date: _____
Tour operator: _____
Departure date: _____ Return date: _____ Total days: _____ No. in party: _____
Destination country: _____ Destination city: _____

SECTION D : ELECTRONIC FUNDS TRANSFER DETAILS

You should ensure that your payment details are correct on this form. We shall not be responsible for any incorrect payments or delays arising as a result of the provision of incorrect information. We cannot accept responsibility for the security of the information on this form until it is received by us. We recommend you provide a cancelled cheque.

Name of the account holder: _____
Name of the bank: _____
Address of the bank: _____
Branch Code: _____ Currency of the account: _____
IBAN / Account Number: _____ SWIFT / BIC Code: _____

SECTION E : CANCELLATION

Reason for cancellation - please tick ONE box only Death Illness Injury

Date and time you became aware of the need to cancel your trip: Date _____ Time _____

Date and time you informed your travel agent or tour operator: Date _____ Time _____

Did you need to cancel as a result of a person NOT booked to travel with you? Yes No

If YES, please state their name and relationship to you.

Name: _____ Relationship: _____

Details of trip costs and refunds due or paid (continue on a separate sheet if necessary).

	Amount Paid	Refund due or paid	
Ticket costs			
Accommodation costs			
Pre-paid excursions / hire car / parking			
Total		-	= Total amount claimed

Details of all those cancelling (continue on a separate sheet if necessary).

Name	Relationship	Date of birth	Insured on this policy?	
			Yes	No

Please detail the reasons for cancellation below (continue on a separate sheet if necessary).

Was a 3rd party involved? Yes No

If YES, please provide their name, address and their insurance/solicitors details:

SECTION F : MEDICAL CERTIFICATE

This form is to be completed by the registered General Practitioner (GP) of the person whose illness/injury/death has caused the claim.

NOTE:

- Any charge made for its completion is the responsibility of the patient or claimant.
- Please answer all questions. Ticks, dashes, "N/A" are not acceptable. Please complete in CAPITALS.
- All information is treated as private and confidential.

Date Trip Was Booked: _____

Name of the patient: _____

Date of birth: _____ How long have you been the patients GP?: _____

Give full description of illness or injury that caused the cancellation:

Onset date of symptoms: _____ Date first consulted: _____ Date of diagnosis: _____

In date order, please advise any previous medical history relevant to the above condition.

At the time that the trip was booked, was the person receiving, or on a waiting list for, or recovering from in-patient treatment in a hospital/
nursing home? Yes No

If YES, Please provide details:

At the time the journey was booked was the patient:

On a hospital waiting list? Yes No _____

Taking any medication relevant to the above condition? Yes No _____

Undergoing any tests or waiting for results of any tests? Yes No _____

Aware of the condition? Yes No _____

Given a terminal diagnosis? Yes No _____

If cancellation has occurred due to a pregnancy related condition, please describe the condition and why the pregnancy necessitates
cancellation:

SECTION F : MEDICAL CERTIFICATE

What date did it become apparent that the travel arrangements should be cancelled? _____

What date did you advise there was a need to cancel the travel arrangements? _____

When would they be fit to travel again? _____

Has the patient been signed off work? Yes No From _____ To _____

Please provide the patient's state of health at the time the holiday was purchased: _____

Was the patient's medical condition stable and under control at the time of booking? Yes No

GP DECLARATION

I have examined the patient and/or referred to their medical records and declare that the information given is correct and no relevant
details have been withheld.

GP Name: _____

Contact number: _____

GP Signature: _____

Date Signed: _____

Surgery Stamp

SECTION G : CONSENT & DECLARATION

Privacy Consent

Where you have shared sensitive personal information, including your health status, property details, and family details, we require your explicit consent for cross-border transfer. By ticking the box below, you consent to the international transfer of the sensitive personal information for policy management, claims processing, and customer support. Your data will be protected under appropriate safeguards, and you may withdraw your consent at any time by contacting ncbainsurance@ncbagroup.com.

I consent

I do not consent

Declaration

I/We declare that the above information is true and correct and that the signing of this claim form also constitutes written authority for NCBA Insurance to inspect or investigate any medical records or details relevant to this claim. I/we further declare that i/ we are aware that any misrepresentation and / or non-disclosure in respect of information provided herein shall render my/our claim null and void.

Name: _____

Signature: _____ Date: _____

(If Corporate)

Name: _____

Designation: _____

Company Stamp and Date: