Dear Claimant,

Re: Cancellation Claim

We are sorry that an incident has occurred during your trip. Please find attached a claim form. Please ensure this is fully completed, signed and returned to us, together with the following supporting documents. We require:

1- The Airlines booking invoice or proof of travel and payment of trip.
2- Airline cancellation invoice. If you are travelling with a 'ticket-less' airline, please provide written confirmation from the airline that the booking has not been used and no refunds issued. For non-package trips, we require written confirmation from the transport/accommodation providers that there is no refund available.
3- Documentation in support of your need to cancel*.

* If cancellation is due to medical reasons, the medical certificate on the reverse of the claim form must be fully completed by the usual *family or treating doctor* of the person whose medical condition gives rise to this claim, regardless of whether they were due to be travelling or not. In the event of bereavement, a copy of the death certificate will also be required.

If any of the above cannot be provided, please enclose a covering letter explaining the reasons for this.

Please note that in order for us to handle your claim as quickly and efficiently as possible, it is necessary that you answer **all** questions and forward all supporting documents. We suggest that you retain copies for your records.

Please contact us on telephone UAE +971 4270 8705 or email: travel.claims@nextcarehealth.com

We look forward to hearing from you.
Yours faithfully,
Travel Claims Department

Only Applicable in case you provide us Medical Health Data

Consent Form

We care about your privacy and the privacy of your family members. In line with the General Data Protection Regulation (GDPR), we need your consent to collect and process your health and other data. **If you do not provide your explicit consent for the processing of your personal data as outlined below, we will not be able to handle your data, provide cashless access to treatment or process any claims that may be owed to you. For more information, please have a look at our privacy notice.**

If you agree, your data will be processed for the following reasons and activities.

The table below needs to be completed only by those members under this policy who have not already provided consent before. Their consent will be valid for the entire duration of their policy unless they decide to change or revoke at any time.

A parent or guardian should complete the consent for any member that is under the age of 18.

By signing this document I agree to the following:

1. **Permission to collect, store and use my health data:** my data is being collected, stored and used in order to administer the policy or process any claims in compliance with the local regulations.

2. **Permission to obtain my data from third parties:** my health and other data may be obtained from physicians, nursing and hospital staff, other medical institutions, care homes, statutory health insurance funds, my Plan Sponsor, professional associations and public authorities to provide me with insurance cover or process any claims. I agree to release all individuals at these institutions and the health insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for these aforementioned stated purposes.

3. **Sharing my data: m**y health data may be shared with the institutions set out below for them to use to the same extent, and for the same purposes as the health insurer. I understand that the health insurer has put in place contractual arrangements with these institutions to protect my data. I agree to release all individuals at these institutions and the health insurer from their respective confidentiality obligations relating to my health data or other data that they are required to share and use for the purposes set out below:
    - With independent medical experts if this is necessary to process my claim as per my insurance policy.
    - With service providers that perform certain services on behalf of the health insurer, such as claims handling that involve the collection and use of my health and other data, without which the health insurer would not be able to administer my policy or pay any claims due to me.
    - With other health insurers/re-insurers that may be covering the same insurance risk at the same time – multiple insurance – to distribute the payment of any compensation that may be owed to me, or to collaborate in the detection or prevention of fraud and financial crime.

If I change my mind about my preferences above, including withdrawing my consent to any of these items, I can let the health insurer know by emailing: Dataprivacy@nextcarehealth.com

Personal Details

Surname: Forename(s):

Title: Date of Birth Address:

Mobile No: Email:

Trip Details

Destination/Country of this Journey:

Date Journey Booked : Date Insurance Purchased:

For Non-Medical Trip Cancellation Claims Please complete the below section:

Date Cancellation became necessary: Date of Cancellation:

Please advise exact cause of cancellation. If cause of cancellation is not of a medical nature, you need to provide suitable documentation in support of your need to cancel.

Amount Claimed (in local currency or US dollars)

Total Journey Cost

Less refunds received

Total Amount Claimed

Have you made a claim and received compensation from any other third parties (e.g. airline, hotel) for Trip Cancellation: Yes No

If so, specify compensation amount received:

Declaration: Insurers and their agents share information to prevent fraud and for underwriting purposes. It is a criminal offence to make a fraudulent claim. Cases are investigated and any person suspected of fraud is reported to the police with whom we always co-operate in effecting a prosecution. I/We declare that the information contained within this claim form is true and correct to the best of my/our belief. I/We assign to Insurers all rights of recovery/salvage against any person or organization and will do whatever else is necessary to secure such rights. I/We agree that Insurers may contact our family or treating doctor for more information if they deem it necessary.

Claimant Name Signature Date

For Emergency Medical Cancellation the below Medical Form to be completed my treating or family doctor:

This form must be completed by the family or treating doctor of the person whose medical condition gives rise to this claim. Any fee for completing this certificate is the responsibility of the patient / claimant.

Name of patient:

Date of Birth: How long have you been the patient's family or treating doctor?

Please confirm exact diagnosis:

Date first diagnosed: Date symptoms first began:

Details of any previous medical history relevant to the above condition including the date of diagnosis

Has the patient been in hospital in the last 12 months prior to booking the journey? If yes, please provide details:

At the time the journey was booked was the patient? (If yes to any of the questions please provide details):

On a waiting list:	Yes	No
Undergoing Test:	Yes	No
Given a terminal diagnosis:	Yes	No
Taking any medication:	Yes	No
Aware of the condition:	Yes	No

In your opinion:

a) Was cancellation medically necessary? Yes No

b) When did cancellation become medically necessary? Date

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

Name of Family or treating doctor: Contact Number:

Signature : Date : Name & Stamp (Stamp Group)