

Cancellation Claim Notification

Kindly fill in and send to

O.F. Gollcher & Sons Ltd

Mailing /Office Address: 19 Zachary Street, Valletta VLT 1133

e-mail: claims@gollcher.com, tel: +356 25691500, fax: +356 21234195

Insured	Full Name: _____ Telephone: _____ Address: _____ E-mail: _____ Postal code/Town: _____ Date of Birth: _____ Policy No: _____
Insurance Period	From: _____ Until: _____
Incident	Travel route: _____ Planned departure: _____ 20____ Time: _____ Planned return: _____ 20____ Time: _____ For cancellation , please explain in detail the reason for your cancellation. (Please note that you are required to enclose documentation for the reason of cancellation e.g. medical certificate, death certificate, confirmation from the employer etc.) _____ _____ _____
	Time and date of the incident: _____ When did you inform the airline that you would not be travelling? _____ 20____ Time: _____ 20____ Time: _____
	Have you received refund from the airlines? : Yes:____ No:____ If yes, amount: _____ Have you been offerd a substitute flight?: Yes:____ No:____ For what date and time? _____

Cancellation Claim Notification cont'd.

Incident	<p>Name and address of all involved co-travelers. What is your kinship?:</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p>
Cancellation - illness	<p>Symptoms that lead to cancellation:</p> <p>_____</p> <p>When did the above mentioned symptoms begin? Date: _____</p> <p>When did you visit a doctor about the above mentioned symptoms?</p> <p>Date: _____</p> <p>Diagnosis: _____ (Please, enclose doctor's certificate)</p> <p>Have you earlier been treated for the above mentioned illness? Yes: ___ No: ___</p> <p>If yes, has your doctor approved your travel plans? Yes: ___ No: ___</p>
Other insurance	<p>Do you have any other insurance, which may cover this cancellation?: Yes: ___ No: ___</p> <p>If yes, please, state:</p> <p>Company name: _____</p> <p>Policy no: - _____</p> <p>Have you filed a claim with the above mentioned company? Yes: ___ No: ___</p>
Signature	<p>I/We hereby declare that the above information and statements are, to the best of my/our knowledge and belief, correct and complete. I/we also hereby agree to give O. F. Gollcher and Sons Ltd. consent to share information contained herein with other insurance companies and third parties in order to verify the information and statements made herein. Furthermore, I/we grant permission for O.F. Gollcher & Sons Ltd to review my medical records.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Signature Date 20</p>