

Dear Claimant,

**Re: Delay/Missed Departure Insurance 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 by post, together with the following original documentation.

1. Proof of your insurance. This may be in the form of a holiday booking invoice or for Internet bookings, an email confirmation.
2. The Airline booking invoice or proof of travel and payment of trip.
3. Your Trip itinerary.

**For Delay Claims**

4. Written confirmation from the transport provider (e.g. airline/ferry Co. etc.) of the scheduled date and time of departure, actual date and time of departure and precise cause of delay.

For travel delay claims, the travel delay benefit will apply in the event that your claim is successful. This is a set amount of money for each complete period of set number hours you are delayed. Please refer to your policy wording for full details.

Regrettably, additional expenses you incur due to a travel delay or loss of earnings are specifically excluded in the general exclusions section of your policy.

**For Missed Departure**

5. Documentation in support of the cause of the claim, car breakdown report etc.
6. Original receipts in support of the expenses being claimed.

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 **original** documents. We suggest that you retain copies for your records. **Please ensure you make it clear who you wish any payment to be made out to if not the claimant.**

The address to return your completed claim forms and supporting documentation to is as follows:

Travel Claims Department,  
Arab Gulf Health Services NEXtCARE,  
Eiffel Boulevard Limited Building (EIFFEL 2) – First Floor  
Sheikh Zayed Road, Near the First Gulf Bank Metro Station  
Umm Al Sheif  
PO80864, Dubai UAE  
Ph: **UAE +971 42708705**  
Email: [travel.claims@nextcarehealth.com](mailto:travel.claims@nextcarehealth.com)

We look forward to hearing from you.

Yours faithfully,  
Travel Claims Department  
NEXtCARE

**CLAIM FORM**

Please ensure all original documents requested are enclosed

Claim Reference No.:

**Personal Details**

Surname:

Forename(s):

Title:  Date of Birth:

Address:

Occupation:

Daytime Tel No:

Postcode:

Evening Tel No:

Mobile No:

E-mail Address:

Cheque to be made payable to:

**Trip Details**

Destination / Country of this Journey:

Date Journey Booked:

Date Insurance Purchased:

Date of Journey:

Date of Return:

Duration: days  No. of People Insured:

Place Insurance Purchased:

Name of Tour Operator (if applicable):

**Travel Insurance Details**

Travel Insurance Policy No/Ref:

What company did you buy your Travel Insurance from?

Other Insurance: Please confirm which Bank you hold current accounts and / or credit cards with:

Bank Name

Credit Card No.

Issued Bank

Date of Expiry

**TRAVEL DELAY, ABANDONMENT, MISSED DEPARTURE FORM**

***Please ensure all original documents requested are enclosed***

Claim Reference No.:

Please give the full name of each insured person claiming (all claims):

Please state the reason given by the airline, shipping line or train company for the cause of the delay:

Please provide details of the **Original** departure and arrival times:

Date:

Departure Time:

Arrival Time:

Please provide details of **actual** departure and arrival times:

Date:

Departure Time:

Arrival Time:

**Abandonment Only**

Total journey cost :

Less refunds received :

Less airport departure tax :   
(If applicable)

Total Amount Claimed :

**Missed Departure**

Please give us full of why you missed your departure, including details of any third party involved:

Please give details of any additional accommodation or travel expenses you incurred as a result of the missed departure:

| Type of Expense | Amount claimed |
|-----------------|----------------|
|                 |                |
|                 |                |
|                 |                |
|                 |                |
|                 |                |
|                 |                |
|                 |                |
|                 |                |

|   |  |
|---|--|
| <b>Total Amount (in local currency or US dollars)</b> |  |
|---|--|

**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.

|               |  |            |  |       |  |
|---------------|--|------------|--|-------|--|
| Printed Name: |  | Signature: |  | Date: |  |
|---------------|--|------------|--|-------|--|