

Cancellation Claim Notification

Kindly fill in and send to

O.F. Gollcher & Sons Ltd

Mailing Address: P.O. Box 268, Valletta VLT 1000, 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: _____ 200__ Time: _____ Planned return: _____ 200__ 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? _____ 200__ Time.: _____ 200__ 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> <hr/> <hr/> <hr/> <hr/> <hr/> |
| Cancellation - illness | <p>Symptoms that lead to cancellation:</p> <hr/> <p>When did the above mentioned symptoms begin? Date: _____</p> <p>When did you visit a doctor about the above mentioned symptoms? 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 hereby declare that the information given is true and correct. Furthermore I grant permission to O.F. Gollcher & Sons Ltd. to review my medical records.</p> <p style="text-align: center;">_____</p> <p style="text-align: center;">Signature Date</p> |