

# Medical Emergency Trip Cancellation Request

## Policyholder/Applicant Details

Full Name

Date of Birth

Policy Number

Contact Number

Email Address

Address

## Trip Information

Destination

Departure Date

Return Date

Booking Reference/Trip ID

## Reason for Cancellation

Please explain the medical emergency and why you are requesting cancellation:

Treating Physician/Medical Facility (Name & Contact)

## **Supporting Documents**

Please attach copies of the following (do not attach here):

- Medical certificate/letter from physician
- Trip booking confirmation/invoice
- Proof of payments made
- Other relevant documents

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Applicant Signature

Date: \_\_\_\_\_

For Office Use Only

Received & Verified by: \_\_\_\_\_