# Travel claim

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

**Return the completed form to your Financial Services Provider or QBE Insurance at:**

**Mail: GPO Box 4323, Melbourne VIC, 3001**
**Email: accidentandhealth@QBE.com**

| **Policy No.** | **57 BERT 000 PAD** | **Claim No.** | |
|---|---|---|---|

IMPORTANT INFORMATION

1. Please complete the policy details section and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully.
3. We may ask for details of your medical history, or of the person whose accident, illness or death necessitated additional expenditure or the cancellation of the journey. Such information must be obtained at your expense.
4. To avoid delay in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
5. Claims may be subject to an excess as described in your Policy.

| | | | | | |
|---|---|---|---|---|---|
| 1. Name of insured person | | | | | |
| 2. Residential address | | | | | |
| | | State | | Postcode | |
| 3. Was an air trip involved in the travel? | Yes ☐ No ☐ | | | | |
| 4. Details of journey | Departure date *(dd/mm/yyyy)* | | Return date *(dd/mm/yyyy)* | | |
| 5. Destination address | | | | | |

## Policy details section

| | | | | | |
|---|---|---|---|---|---|
| Claimant name (block letters) | | | | | |
| Postal address | | | | | |
| | | State | | Postcode | |
| Date of birth *(dd/mm/yyyy)* | | | | | |
| Contact numbers | Business | | Private | | |
| | Facsimile | | Mobile | | |
| Travel agent | | | Telephone No. | | |
| Date of booking travel arrangements *(dd/mm/yyyy)* | | Date of Departure *(dd/mm/yyyy)* | | | |
| Date of return *(dd/mm/yyyy)* | | | | | |

Have you made previous claims for travel insurance? Yes ☐ No ☐ – If "Yes", please give details

| Name of insurer | Date of claim *(dd/mm/yyyy)* |
|---|---|
| | |
| | |

## Claim payment details – electronic funds transfer

For fast payment claims please provide your bank account details below:

| | | | |
|---|---|---|---|
| Name of bank | | | |
| Account name | | | |
| BSB: | | Account number | |

## Section 1. cancellation claims

**The following documents are required in support of your claim Please tick (✓) when attached**

Doctor's certificate (see section 4) ☐ Travel agent's letter confirming details of tour costings and cancellation charges ☐

Transport provider's reports ☐

## Section 1. cancellation claims

Reasons for cancellation

| | | |
|---|---|---|
| Date of cancellation *(dd/mm/yyyy)* | | |

Where cancellation was due to accident, illness or death, please state the name of the person whose accident, illness or death necessitated the cancellation:

| | | | |
|---|---|---|---|
| Name | | Relationship to insured | |
| Amount claimed for irrecoverable prepaid travel costs $ | $ | | |

## Section 2. luggage and personal effects

**The following documents are required in support of your claim Please tick (✓) when attached**

| | | | |
|---|---|---|---|
| Police or responsible authority's report ☐ | | Original purchase receipts/proof of ownership ☐ | |
| Quotation for repair of damage ☐ | | Transport provider's reports ☐ | |
| Date of loss | | Time | am/pm |
| Location | | Country | |

Please state exactly what happened.

If space is insufficient, please attach details and a sketch if necessary.

What action did you take to recover the lost articles?

If space is insufficient, please attach details.

Which responsible authority (e.g. Police) was notified?

| | | | |
|---|---|---|---|
| | | Location | |
| Date notified | | Time | am/pm |

## Section 3. medical emergency and additional expenses claims

**The following documents/statements are required in support of your claim Please tick (✓) when attached**

| | | | | | |
|---|---|---|---|---|---|
| Original medical/hospital accounts detailing illness/medical condition ☐ | | | Accounts in support of accommodation expenses ☐ | | |
| Medical certificate supporting need for altered travel plans ☐ | | | Copy of Travel Itinerary ☐ | | |
| Date of accident, illness or circumstances | | Time | am/pm | Country | |

Particulars of claim.

If your claim arises from injury or illness, please specify the nature of such injury or illness.

| | |
|---|---|
| Name of person whose injury or illness caused additional expenditure | |
| Their relationship to you | |

## Section 3. medical emergency and additional expenses claims

| | | | | |
|---|---|---|---|---|
| Has the illness or injury occurred before? Yes ☐ No ☐ – If "Yes", please supply the following details | | | | |
| Usual Doctor's name | | | | |
| Doctor's telephone No. | | Date of last visit | | |
| If additional expenses have been incurred as the result of an accident, illness or death of a person in Australia, please state: | | | | |
| Their relationship to you | | | | |

| Expenditure for which reimbursement is claimed | | Amount claimed |
|---|---|---|
| 1. Provider (eg. Dr. J. Smith, Bali Hospital etc.) | Service (i.e. Medical, Hospital etc.) | |
| | | |
| | | |
| | | |
| | | |
| | | |
| 2. Additional expenses | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| 3. Cancellation/Loss deposits (Please attach documents from your travel agent showing cancellation charges) | | |
| | | |
| | | |
| | | |

## Medical authority

With regards to medical, cancellation and/or additional expenses –

I hereby authorise any hospital, physician or other person who has attended or examined me to furnish to QBE or their representative any and all information in respect of treatment given for:

A photostat copy of the this authorisation shall be considered as effective and valid as the original.

| | | | | | |
|---|---|---|---|---|---|
| Name ofusual Doctor | | | | | |
| Address of usual Doctor | | | | | |
| | | State | | Postcode | |

**Medical authority:** I authorise any hospital, physician or other person who attended me, to give QBE or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

A photocopy of this authorisation will be considered as effective and valid as the original.

| | | | |
|---|---|---|---|
| Signature of insured person | 1. | Date | |
| Signature of insured person | 2. | Date | |

## Section 4. medical certificate - completion by Doctor

To be obtained at the claimant's expense from the patient's usual medical practitioner in Australia (or specialist where applicable) in cases of medical claims and cancellation or additional expenses claims exceeding $500 resulting from accident, illness or death.

Name of person to whom this certificate applies (i.e. the person whose accident, illness or death necessitates the completion of this certificate)

| | | |
|---|---|---|
| | Age | |

| | |
|---|---|
| Are you his/her usual medical attendant? Yes ☐ No ☐ – If "Yes", for how long? | |
| Please give precise details of the nature of the illness or injury | |
| | |
| Please state the date of the onset of the illness, or the date on which the injuries were sustained | |
| Please state the date you were first consulted for this condition | |
| Have you previously treated this patient for the same/similar/related condition as described above? Yes ☐ No ☐ | |
| If "Yes", please state when | |
| To the best of your knowledge has any other doctor previously treated this patient for the same/similar/related condition? Yes ☐ No ☐ | |
| If "Yes", please state the last time, and what treatment and/or medication was prescribed. | |
| | |
| Was the patient advised not to undertake travel, as a result of any illness/injury? Yes ☐ No ☐ | |
| If "Yes", please provide details including date of advice: | |
| | |
| Was the patient advised to continue this treatment and/or medication whilst away? Yes ☐ No ☐ | |
| Are you prepared to certify that solely due to the condition described above, the claimant(s) is/are compelled to cancel the travel arrangements? Yes ☐ No ☐ | |
| I certify that the foregoing statements are correct | |

| | | | | | |
|---|---|---|---|---|---|
| Doctor's Name | | | | | |
| Doctor's Address | | | | | |
| | | State | | Postcode | |
| Doctor's Qualification | | | | | |
| Doctor's Signature **X** | | Date *(dd/mm/yyyy)* | | | |

## Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our **Privacy Policy** at **www.qbe.com.au/privacy**, or to obtain a copy by phoning us on **133 723** or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

## Declaration

The information and answers given above are true, correct and complete in every detail.

1. I/We understand the claim may be refused if information is not true or is withheld.
2. I/We authorise QBE to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Insured Person

Date *(dd/mm/yyyy)*

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM