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ACCIDENT & HEALTH INTERNATIONAL

Claim Form

TRAVEL INSURANCE

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. **Please answer all questions and provide all relevant documentation to avoid delays with your claim. We are unable to process any claims until all information requested on this form is provided.**
2. **Please note that Sections 1, 2, 4, 5 & 12 are compulsory.**
3. **Note: This form can be completed electronically. If completing this form by hand: Please print.**
4. **The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Limited.**

SECTION ONE: YOUR DETAILS - ALL QUESTIONS ARE REQUIRED TO BE COMPLETED

Policy Number: 5551832

Expiry Date: 31/12/2019

Name of Insured Company: University of Tasmania

Your Position

- ☐ CEO/CFO/COO
- ☐ Director
- ■ Employee
- ☐ Contractor
- ☐ Spouse
- ☐ Dependent Child
- ☐ Other

Title

Given Name(s)

Family Name

Date of Birth

Residential Address

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

Are you able to claim through any other source? ☐ Yes ☐ No

If Yes, please provide details:

Have you made previous travel insurance claims? ☐ Yes ☐ No

If Yes, please provide details:

SECTION TWO: PAYMENT DETAILS - COMPULSORY

Please tick preferred method of Payment for refund.

☐ Cheque

Payee

■ Direct/EFT Payment

Account Holder's Name: University of Tasmania No.1 Account

BSB Number (6-Digits): 067-102

Account Number: 000503503

Bank: Commwealth Bank

(alternatively supply a deposit slip noting the following information)

SECTION THREE: GST DECLARATION

Must be completed *ONLY* in respect of:

- Each company owned item
- Any other expenses where Australian GST is incurred by the company.

Are you registered for GST Purposes? ☐ Yes ☐ No

If Yes, What is your ABN?

Have you claimed, or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? ☐ Yes ☐ No

If YES, what percentage of ITC did you claim or are you entitled to claim?

SECTION FOUR: TRAVEL INFORMATION - COMPULSORY

Departure Date

Return Date

Departure City

Destination City

Departure Country

Destination Country

Reason For Travel

☐ Business / Work ☐ Holiday ☐ Combination ☐ Other

SECTION FIVE: DETAILS OF INCIDENT - COMPULSORY

Date of Incident | Time | AM / PM | Incident City | Incident Country

Please describe how the accident / damage / theft / loss / illness occurred and complete relevant sections :

SECTION SIX: MEDICAL EXPENSES - (IF APPLICABLE)

- **This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.**
- Medical Receipts will be required to accompany this section.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the curtailment of the journey.
- All medical and hospital accounts incurred within Australia must first be submitted to Medicare for refund, also to your private health fund if applicable.

Was the Emergency Assistance Company contacted? ☐ Yes ☐ No

If an Illness, has the claimant suffered this complaint before? ☐ Yes ☐ No

If Yes, please provide details:

Date of Expense	Medical and/or Hospital Expenses *(use separate sheet if insufficient space)*	Amount Claimed (Please state currency)

SECTION SEVEN: LOST, STOLEN OR DAMAGED LUGGAGE & PERSONAL EFFECTS - (IF APPLICABLE)

- In the event of loss or damage occurring whilst in the care of carriers (airlines, bus companies, etc) the carrier should have been notified and a Property Irregularity Report obtained and forwarded with this form.
- Full description of articles lost or damaged with details of the nature of damage, full particulars of purchase price and date and place of purchase are to be entered on the statement of claim below, together with proof of lost or damaged goods (e.g. Receipts, Valuation, Certificates, Credit Card Statements).
- You should obtain an estimate for repairs where feasible or written confirmation from a competent repairer or dealer that the articles are damaged beyond economic repair.
- All optical expenses must first be submitted to your health fund, if applicable.
- Lost/Stolen goods should be reported to the Police.

Was the incident reported to Police or any other authority? ☐ Yes ☐ No

If Yes, please provide report / Incident No.

If No, please provide explanation:

Were articles lost by a carrier? ☐ Yes ☐ No

Note: The Warsaw Convention & The Montreal Conventions imposes a liability upon the carrier and you should claim against them first.

Were all the missing articles your property? ☐ Yes ☐ No If No, Who is the owner?:

Have you lodged a claim or complaint against any Carrier/Airline or other authority or against any individual responsible for the loss or damage to your property? ☐ Yes ☐ No

If Yes, please provide details and attach correspondence:

If No, please provide explanation:

If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? ☐ Yes ☐ No

Name of Fund

Membership No.

Amount Paid by Health Insurer

$

Currency

SECTION EIGHT: DELAYED BAGGAGE - (IF APPLICABLE)

Date of Your Arrival

Time

AM / PM

Compensation Paid by Carrier

$

Currency

Date of Luggage Arrival

Time

AM / PM

STATEMENT OF CLAIM

ATTACH SEPARATE SHEET IF INSUFFICIENT ROOM

Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the damage where applicable.

Please attach relevant documentation to support your claim, e.g. receipts, photographs, manuals.

Full description of article/s & details of damage where applicable (provide evidence)	Original Cost Price	Date and Place of Purchase	Has item been replaced	ITC %	Amount Claimed	CUR
Dell Latitude x150 - Cracked Monitor - photo #1	*$2600 AUD*	*26/06/2010 - Dell Website*			*$2600.00*	

SECTION NINE: ADDITIONAL AND/OR FORFEITED EXPENSES - (IF APPLICABLE)

- **This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.**
- Only original accounts or receipts for, accommodation and transport costs will be accepted.
- **For additional expenses, a MEDICAL CERTIFICATE, or the Medical Certificate on Page 6 of this form, from the doctor who treated you must be provided to support change of plans due to accident, illness or death.**

If you are claiming for additional expenses, what were your original plans for accommodation/transport and how were they changed?
Please ensure copies of original and amended itineraries are provided.

Date of Expense	Additional Transport / Accommodation Expenses *(Please Supply Full Details)*	Amount Claimed (Please state currency)

Date of Expense	Forfeited Expenses *(Please Supply Full Details)*	Amount Claimed (Please state currency)

SECTION TEN: HIRE CAR EXCESS EXPENSES - (IF APPLICABLE)

Please ensure a copy of your Hire Vehicle Agreement, Damage Report and repair invoice(s) are attached.

Type of Vehicle

☐ Car ☐ Other

Name of Vehicle Hire Company

Title

Driver's Full Name

Rental Vehicle Excess $ Currency

Actual Repair Costs $ Currency

Amount you are claiming $ Currency

SECTION ELEVEN: CANCELLATION / LOSS OF DEPOSITS - (IF APPLICABLE)

- **If you are claiming because you cancelled your trip PRIOR to departure, as a result of injury, illness or death, you MUST have the Medical Certificate on Page 6 completed by the regular doctor of the person whose state of health has resulted in the claim.**
- **We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the cancellation of the journey.**
- **A supporting document from the travel provider showing cancellation charges must be submitted with this form.**

Date travel arrangements booked:

Date of Cancellation:

Reason for Cancellation:

If cancellation is due to accident, illness or death state the name of the person whose accident, illness or death necessitates the cancellation of the travel.
IN THE EVENT OF DEATH, PLEASE ATTACH DEATH CERTIFICATE

Title

Given Name(s)

Family Name

Relationship of person to claimant:

Amount Paid

Currency

Amount Refunded

Currency

Amount Claiming

Currency

$

$

$

If no refund amount is noted please state why (you must obtain all refund possible)

SECTION TWELVE: DECLARATION - COMPULSORY

Dispute Resolution Statement
Accident & Health International Underwriting Pty Ltd is an agent for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.
If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within fifteen (15) working days. If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme.
Access to the Dispute Resolution scheme is free of charge to you.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:
I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We agree that, by submitting this form, the personal information I/We provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in our Privacy Policy including for the processing of this claim.

Authority
I authorise any hospital and/or physician who has treated me to provide Accident & Health International with copies of medical records or of my past medical history, as requested.

Signature of Claimant

Date

Signature of the Insured *(if other than claimant)*

Date

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ACCIDENT & HEALTH INTERNATIONAL
MEDICAL CERTIFICATE

THE CLAIMANT MUST OBTAIN AT OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES OF CANCELLATION AND MEDICAL CLAIMS RESULTING FROM ACCIDENT, ILLNESS OR DEATH.

IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRES

SECTION THIRTEEN: PATIENT DETAILS

Title | Given Name(s)

Family Name | Date of Birth

1. Are you his/her usual medical attendant? ☐ Yes ☐ No

2. If Yes, for How long?

☐☐ Days ☐☐ Months ☐☐ Years

3. Please give precise details of the nature of the illness or injury.

4. Start date of onset of illness, or date

☐☐☐☐☐☐☐☐

5. State date on which you were first consulted in relation to the condition described above and, in your opinion, how long the condition has been present prior to consultation.

First Consultation Date ☐☐☐☐☐☐☐☐ | Condition has been present prior to consultation for:

6. Are you prepared to certify that solely due to the condition described in question 4, the claimant/s was/were compelled to cancel the travel arrangements? ☐ Yes ☐ No

7. What treatment, if any, has your patient previously received for this or any other related condition, and when was treatment received?

8. Is he/she suffering from any chronic disease or illness or from any physical defect or infirmity?

9. If the claim is as a result of a death, in your opinion, was it sudden and unexpected? Please give reasons for your answer.

Print Name: | Qualification: | Signature of Doctor

Address: | Phone: | Fax

Date ☐☐☐☐☐☐☐☐