Travel Insurance

Claim form

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

CLAIMANT DETAILS

1. Name of Insured:
2. Policy Number:
3. Name of Traveller: ○ Mr ○ Mrs ○ Miss ○ Ms
4. Occupation: Date of Birth:
5. Address:

   Post Code:
6. Telephone – Home: Mobile:
7. Email:

TRAVEL INFORMATION

8. Date of Departure: Scheduled return date:
9. Departure Country: Departure City:
10. Destination Country: Destination City:

PAYEE'S BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.

11. Please complete the following:

    Bank:

    SWIFT code (For Non-Australian Bank): | | | | | | | | | | | |

    Account Holder's Name(s):

    BSB Number: | | | | | | | Account Number: | | | | | | | | | | | | | | | | |

TRAVEL INSURANCE CLAIM FORM

This form must be fully completed in the sections applicable to your claim and signed.

ALL SECTIONS MUST BE ANSWERED

12. Give full details of how loss, damage, theft or incident occurred: (Detail each event)

13. Date of occurrence: Time: ○ am ○ pm

14. Date loss reported: Time: ○ am ○ pm

15. Loss reported to – Name:

16. Address:

BAGGAGE AND PERSONAL EFFECTS

17. Were articles lost by Carrier? (e.g. Airline) ○ Yes ○ No

Name:

18. Have you yet 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? If so, please give details and attach copies of correspondence.

NOTE: The Warsaw Convention imposes a liability upon the Carrier and you should claim from them first.

Airline	**Claim No.**

19. Are any of the items covered by other Insurance? ○ Yes ○ No

If 'Yes' – which Company?

20. Were all the missing articles your property? ○ Yes ○ No

If 'Yes' – who is the owner?

Description and size of suitcase in which missing goods carried:

Full details of articles claimed (include value of cases)	**Name and address from whom goods were purchased**	**Date of purchase**	**Purchase price**	**Amount claimed**	**Remarks**

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM:

- Report or letter from Authority (e.g. Police, Airline) regarding the loss, where available;
- Proof of purchase of lost goods (e.g. Receipts, Guarantee or Valuation Certificates, Card Vouchers, etc.);
- Invoice or quotation to replace the item with another of a similar style and quality.

Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason.

PERSONAL MONEY AND TRAVEL DOCUMENTS

21. Date notified: To whom:
22. Which police were advised? State Police Station and attach copy of report if available.
23. Description of the incident:

24. Details of claim:

MEDICAL EXPENSES

25. Diagnosis of Injury or Sickness:
26. Date of Accident or Commencement of sickness:
27. Injury – Give full details of Accident:

28. Date of First Medical Consultation: Name of Doctor or Hospital:
29. Details of other treatment:
30. Dates in hospital: Admitted: ○ am ○ pm Discharged: ○ am ○ pm
31. Have you ever suffered from the same or a similar complaint in the past? ○ Yes ○ No

    If 'Yes', give details, dates, etc.:

32. Do you have a Medicare Card? ○ Yes ○ No
33. Are you a member of a Private Health Insurance Fund e.g. Medibank? ○ Yes ○ No

    If 'Yes', please name Fund:

    N.B. For ongoing expenses incurred after your return to Australia, if you are a member of a Private Health Fund you must claim from that fund before submitting this claim.

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*:

- Doctor's / Hospital accounts and receipts together with statements from Medicare and Private Health funds;
- Original Doctor's Certificate.

*Failure to provide these items may result in delays in processing your claim. If it is not possible to provide any of the items please advise the reason:

CANCELLATION AND CHANGES TO YOUR TRIP

34. What was the reason you could not commence/continue your proposed journey or complete the return flight?

35. Was the cancellation as a result of Injury/Sickness to yourself? ○ Yes ○ No

36. Was the cancellation as a result of Injury/Sickness to some other relative or person as defined in the Policy? ○ Yes ○ No

    If 'Yes', please fill in the below:

    Name:

    Address:

    Relationship: Age:

37. Nature of complaint preventing travel:

38. Date of first Medical Treatment:

39. Has the Injured / Sick person had a similar condition in the past? ○ Yes ○ No

40. Name and address of patient's normal Doctor:

41. Date you advised Travel Agent to cancel bookings:

42. Amount of Deposit paid: $ Date paid:

43. Balance of Full Fare: $ Date paid:

44. TOTAL PAID: $

45. Refund received on cancellation: $ (excluding Insurance Premium)

46. Were any alternative arrangements offered or made? (Give details)

47. Were any additional fares incurred as a result of cancellation? (Give details)

COMPLETE THIS SECTION FOR ADDITIONAL EXPENSES

48. Reason for incurring additional expenses or forfeiting travel or accommodation expenses:

49. Details of expenses incurred:

	A$
	A$
	A$
	A$
Total:	**A$** 0

50. Were these expenses incurred as a result of the Injury or Sickness reported in question number 25? ○ Yes ○ No

51. If these expenses were incurred as a result of Injury or Sickness to any other person, please give details of cause, name, address and age of person.

    Cause:

    Name and Details:

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*:

- Original receipts and/or Tickets relating to additional expenses incurred;
- Evidence of refunds payable or that fare/accommodation is not refundable;
- Proof of cause i.e. Original Doctor's/Hospital's Certificate relating to Injured or Sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport.

  *Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the items please advise the reason:

ACCIDENTAL DEATH CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*:

- Copy of original of the Death Certificate;
- Copy of Coroner's Depositions and Findings (if applicable);
- Copy of original Birth Certificate.

  ***Failure to provide these items may result in delays in processing your claim.**

52. When did the accident occur? Date: Time: ○ am ○ pm
53. Please detail how the accident occurred:

54. Was a coronial inquest held or is one to be held? ○ Yes ○ No

    If 'Yes', please give details:

55. Name and Address of usual family doctor:

56. How long has the doctor been known to the patient?

RENTAL VEHICLE EXCESS CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*:

- The Hire Care Agreement;
- Notice from the Hire Care Company in respect of the excess or deductible;
- Documentation evidencing payment of excess or deductible;
- A copy of the Hire Care Repair Invoice from the Hire Company.

  ***Failure to provide these items may result in delays in processing your claim.**

57. Please provide a full description of the circumstances of the incident giving rise to the claim:

    Date of Event:

    Description of accident and damage:

PERSONAL LIABILITY

58. Date of Event: at ○ am ○ pm or between ○ am ○ pm and ○ am ○ pm

59. Where did the event occur?

60. Brief Description (including cause of loss or damage):

61. Amount claimed (as shown on the Schedule): $

62. Have you received/anticipate receiving Notice of any Claim from or on behalf of Third Parties? ○ Yes ○ No

If 'Yes', give details including name, address and email or telephone number of third party(ies):

CLAIM LODGEMENT DETAILS

63. **PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES:**
(Please keep a copy of all documents sent to Proclaim)

Email Address (preferred): ahclaims@proclaim.com.au

Fax No: 1300 858 329

Or by Postal Address:

Proclaim Pty Ltd
Locked Bag 32012
Collins Street East
VIC 8003

Phone Number: Once the claim form has been completed, sent, and received by Proclaim, claim inquiries can be made to Proclaim on: +61 (2) 9287 1302

Policy and coverage queries should first be directed to your Insurance Broker.

PRIVACY STATEMENT

Proclaim are committed to protecting your privacy. We use the personal information you provide to us in connection with your claim only for the purpose of assessing and managing the claim. We may need to provide that information to our underwriters and those we appoint to assist us with the claim. We will not trade, rent or sell your information. If you do not provide us with complete information, we cannot properly assess your claim. You can check the personal information we hold about you at any time. If you provide us with personal information about anyone else, we rely on you to have told them that you will provide their information to us, to whom we may provide it, the purposes for which we will use it and that they can access it. If the information is sensitive, we rely on you to have obtained their consent on these matters.

DECLARATION AND AUTHORISATION - COMPLETE FOR ALL CLAIMS

I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.

I authorise any hospital, physician or other person who has attended me or any other Insurer to furnish the claims managers, Proclaim, with any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, treatment, copies of all hospital or medical reports, information on other claims for the same Injury or Sickness or any other information necessary to complete the assessment of my claim on request.

I authorise any travel agent or airline to furnish the claims managers, Proclaim, with any and all information with respect to the circumstances of the lodged claim or any other information necessary to complete the assessment of my claim on request.

I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Signed: Date:

POLICY HOLDER VERIFICATION

To be completed by a representative of the Insured for all claims on Business Travel Policies

I, (Company Representative):

Confirm that (Insured Person):

Is an employee of:

And is entitled to claim against the Company's Business Travel Policy No:

Signature: Contact Number:

Name: Title:

RESET FORM SAVE AS PDF

T: 02 9287 1302 F: 1300 858 329 E: ahclaims@proclaim.com.au
Locked Bag 32012, Collins Street East VIC 8003 ABN: 74 087 666 484
This claim is administered by our Third-Party Administrator (TPA), ProClaim.