Travel Insurance Claim Form

### 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. This form consists of several sections. Please provide answers to all the information required in order to avoid delays with your claim.
3. When completing this form please print.
4. The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Limited.
5. Please send completed for to:

Claims Department  
Victorian Managed Insurance Authority  
PO Box 18409, Collins St East, Melbourne 8003

OR Facsimile 9270 6911 OR email [claims@vmia.vic.gov.au](mailto:claims@vmia.vic.gov.au)

|  |
| --- |
| Policy and personal information – All questions require completion |
| Policy number:       Expiry date:      /     / |
| Name of insured company: |
| Name of claimant: |
| Address: |
| Telephone: Home       Mobile       Business |
| Email: |
| Occupation: |
| Name of broker (if known): |
| Please tick preferred form of payment for refund:  Cheque  Please nominate payee:  Direct/ EFT payment  Please supply the following details of a deposit slip noting the following information:  Bank:                 Account holder’s name:  BSB (branch number):                 Account number: |
| Was this authorised business travel? Yes  No |
| Date of departure:      /     /      Date of return:      /     / |
| Exact place where claim occurred: |
| Are you an employee of the insured company? Yes  No |
| Are you able to claim through any other source? Yes  No  If Yes, please provide details: |
| Have you made previous claims in respect of travel insurance? Yes  No  If Yes, please provide details: |
| GST DECLARATION Must be completed by the *Financial Controller 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? |

|  |
| --- |
| Baggage and personal effects and/or money |
| 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. |
| Date of loss/theft/damage:      /     /      Time:            am/pm |
| Please state exactly what happened: |
| State action taken to recover lost articles: |
| Were the police notified? Yes  No  If yes, at what police station?            Report No./ Event No. |
| Were articles lost by a carrier? Yes  No  *Note: The Warsaw Convention imposes a liability upon the carrier, and you should claim on them first* |
| Have you lodged a claim or complaint against any Carrier/Airline or other  authority or against any individual responsible for loss or damage to your property? Yes  No  If Yes, give details and attach copies of correspondence:  If No, please provide an explanation: |
| Were all the missing articles your property? Yes  No  If no, who is the owner? |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| 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 articles/s  & details of damage where  applicable (provide evidence)** | **Original cost price** | **Date and place of purchase** | **Tick if item has been replaced** | **ITC %** | **Amount claimed** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
|  |  |  |  |  |  |

|  |
| --- |
| Medical, additional and/or forfeited expenses |
| 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 medical, accommodation and transport costs will be accepted.  All medical and hospital accounts incurred within Australia must first be submitted to Medicare for refund, also to your private health fund if applicable.  For additional expenses, a MEDICAL CERTIFICATE, or the Medical Certificate on Page 5 of this form, from the doctor who treated you must be provided to support change of plans due to accident, illness or death.  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. |
| Date of accident/ illness:      /     /      Time:            am/pm |
| Cause of claim (include details of illness/ injury if applicable): |
| 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. |
| If an illness, has the claimant suffered this complaint before? Yes  No  If yes, give details: |
| Was the Emergency Assistance Company contacted? Yes  No |
| If the claim results from the state of health of someone other than you:  Name of person:  Date of birth:      /     /  Relationship of person to claimant: |

|  |
| --- |
| LIST OF EXPENDITURE FOR WHICH REIMBURSEMENTS CLAIMED  (include amount claimed and state currency) |
| Medical and/or hospital expenses: |
| Additional transport/ accommodation expenses (please supply full details): |
| Forfeited expenses: |

|  |
| --- |
| Cancellation / Loss of deposits |
| If you are claiming because you cancelled or postponed your trip PRIOR to departure, as a result of injury, illness or death, you MUST have the Medical Certificate on Page 5 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 agent 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  Name & relationship to claimant: |
| Amount paid: $       Amount refunded: $      Amount claiming: $  If no refund amount is noted please state why (you must obtain all refund possible): |
| You must also have the Medical Certificate Section of this claim form completed by the Attending Physician. We will be unable to process your claim without the Certificate or an appropriate Medical Statement (answering relevant questions as per claim form certificate). |

|  |
| --- |
| Hire car excess expenses |
| Please ensure a copy of your Hire Agreement, Damage Report and any invoicing is attached.  Date damage occurred:      /     / |
| Please state exactly what happened: |

|  |
| --- |
| DECLARATIONS – COMPULSORY SECTION – REQUIRED COMPLETION |
| Dispute Resolution Statement Accident & Health International Underwriting Pty Ltd is an agent for Allianz Australia Insurance Limited who is a signatory 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 staff 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. Privacy: The Privacy Act 1988 requires us to tell you that on behalf of the Insurer we collect your personal information and sensitive information in order to calculate your loss and entitlements, determine our liability, compile data and handle claims.  When handling claims we may have to disclose and request your personal and other information to and from third parties such as other insurers, reinsurers, loss adjusters, medical attendants, external claims data collectors, investigators and agents, to the Insurance Reference Services (IRS), or other parties as required by law.  You have the right to seek access to your personal information and to correct it at any time. Please contact Accident & Health and advise us of the changes. 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 acknowledge that I/We have read and understood the Privacy Act 1998 information referred to above and consent to the collection, storage and use and disclosure of personal and sensitive information of all persons affected by this claim, with their consent. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information then Accident & Health will be unable to process my/our claim.  Signature of the claimant: …………………………………. Dated:      /     /  Signature of the insured: ………………………………….. Dated:      /     /  (if other than claimant) |

|  |
| --- |
| 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 ENQUIRIES |
| Name of person to whom this certificate applies (i.e. the person whose accident, illness or death occurred): |
| Age:  Date of birth:      /     / |
| Are you his/her usual medical attendant? Yes  No  If so, for how long? |
| Please give precise details of the nature of the illness or injury: |
| State date of onset of illness, or date injuries were received:      /     / |
| Date on which you were first consulted in relation to the condition described in Q4:      /     /  In your opinion, how long the condition has been present prior to consultation: |
| 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 |
| What treatment, if any, has your patient previously received for this or any other related condition,  and when was treatment received? |
| Is he/she suffering from any chronic disease or illness or from any physical defect or infirmity? |
| If the claim is as a result of a death, in your opinion, was it sudden and unexpected?  Please give reasons for your answer: |
| I certify that the foregoing statements are correct:  Doctor signature: ……………………………………………. Date:      /     /  Print name:       Qualification:  Address:  Telephone:       Fax: |

Any personal information you provide (or provided by a third-party such as a government body) in this Form is being collected by the VMIA for the purpose of administering VMIA’s functions, under s6 of the Victorian Managed Insurance Authority Act 1996 (Vic), namely to provide insurance, risk advisory and claims handling services. Any personal information you provide will be treated according to the requirements of the Privacy and Data Protection Act 2014 (Vic), the Information Privacy Principles and the Victorian Protective Data Security Standards. VMIA will not act or engage in any practice that contravenes these provisions. Information will be handled in line with VMIA's Privacy Policy. You have the right to access and correct your personal information. Requests for access should be sent to the Privacy Officer, VMIA, PO Box 18409, Collins Street East, VIC 8003 or privacy@vmia.vic.gov.au.