



Travel Insurance Report Form

IMPORTANT INFORMATION

Please ensure this Form is completed in all Parts applicable to your claim. The Privacy Consent on the back, must be completed for all claims. Supporting documentation required is detailed below each Part. The issue and acceptance of this Form does not constitute an admission of liability by the Company or a waiver of its rights.

Policy and Claimant Details

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Name of Policyholder
Name of Claimant: (Mr/Mrs/Miss/Ms)
Policy Number / Credit Card Number (if applicable)
Address:
Telephone: Home: Business:
Email:
Date of Birth: Occupation:
Travel Agent: Date of Booking Travel Arrangements:
Date of Departure: Date of Return:

Electronic Funds Transfer Details

Following ACE approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

Name of Financial Institution: Account Name:
BSB Number: Account Number:

GST Information

(a) Are you registered for GST Purposes? Yes No
(b) What is your Australian Business Number (ABN)?
(c) 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
(d) IF YES, what percentage of the GST did you claim or are you entitled to claim? %

CANCELLATION CHARGES, LOSS OF DEPOSIT CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM *

1. The Original Tickets/Vouchers if a refund is not obtainable.
2. Doctor's/Hospital Certificate specifying exact nature of condition suffered by Injured/Sick person.
3. Letter from Travel Agent verifying total cost of journey, value of unused portion of journey, cancellation charges incurred and total amount of refund received.

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

What was the reason you could not commence or complete your proposed journey?

Was the cancellation as a result of Injury/Sickness to yourself?

Yes No

Was the cancellation as a result of Injury/Sickness to some other relative or person as defined in the Policy?

Yes No

If so - Name

Address

Relationship

Age

Nature of complaint preventing travel

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Date of First Medical Treatment

	/		/	
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Has the Injured/Sick person had a similar condition in the past?

Yes No

Name and Address of Patient's normal Doctor

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Date you advised Travel Agent to cancel bookings

	/		/	
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Amount of Deposit paid and date paid

\$

Date

--

Balance of Full Fare and date paid

\$

Date

--

Value of Forfeited Portion of Journey (if applicable)

\$

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Refund received on cancellation

\$

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Full amount being claimed

\$

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Were any alternative arrangements offered? If so, give details

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Did you accept any of the alternative arrangements?

Yes No

What additional fares did you incur as a result of the arrangement?

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OVERSEAS MEDICAL, DENTAL AND/OR HOSPITALISATION BENEFIT CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Original Doctor's/Hospital accounts and receipts together with details relating to medical benefit refunds.
2. Original Doctor's Certificate verifying nature of complaint suffered by you.

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

Type of Injury or Sickness

Date of Accident or Commencement of Sickness

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If injury - Give full details of Accident

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Date of First Medical Consultation

Name of Doctor or Hospital

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Details of other treatment by Doctors/Hospital

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Dates in Hospital

Admitted / / am/pm

Discharged / / am/pm

List the Country and the currency of the Country in Which you incurred the medical costs

Country:

Currency:

Total Amount

Country:

Currency:

Total Amount

Have you ever suffered from the same or similar complaint in the past?

Yes

No

If Yes, give details, dates names and addresses of treating physicians

Name and Address of usual family doctor

How long has the doctor been known to the patient?

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Are you a member of a Private Health Insurance Fund, e.g. Medibank? Yes No

Name of Fund

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PLEASE NOTE: All medical accounts must first be lodged with your Private Health Fund, if applicable

The policy is only able to consider Non-Medicare claimable expenses.

EMERGENCY EXPENSES CLAIM

(For additional travel and accommodation incurred during the journey)

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Receipts and/or Tickets relating to additional expenses incurred.
2. Doctor's/Hospital Certificate specifying exact nature of condition suffered by Injured/Sick person.
3. Letter from Travel Agent or carrier verifying reason for additional expenses and/or any refund applicable.

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

Date/s Expenses Incurred

Reason for incurring additional travel or accommodation expenses

List the Country and the Currency of the Country in which you incurred the costs

Country:

Currency:

List specifically the additional TRAVEL expenses

Details	Amount
	A\$
	A\$
	A\$
	A\$
TOTAL	A\$

List specifically the additional ACCOMMODATION expenses

Details	Amount
	A\$
	A\$
	A\$
	A\$
TOTAL	A\$

Were these expenses incurred as a result of Injury or Sickness as claimed in Part 1?

Yes

No

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

Name

Age

Address

Relationship

Cause

ACCIDENTAL DEATH CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The Original Policy Document.
2. Original of the Death Certificate which will be returned to you.
3. Copy of Coroner's Depositions and Findings (if applicable)
4. Original Birth Certificate which will be returned to you.

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

What was the cause of death?

When did the accident occur?

	Time	am/pm
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Was a coronial inquest held or is one to be held? If so give details

Yes No

Name and Address of usual family doctor:

How long has the doctor been known to the patient?

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PERSONAL LIABILITY CLAIM

THE FOLLOWING ITEM MUST BE INCLUDED WITH THIS CLAIM*

1. Letters or Demands of a claim made on you.

***Failure to provide this item may result in delays in processing your claim.**

Bodily Injury - Provide relevant details - Name and Address of Injured Party and details of injury

Damage to Property - List all Property Damage together with Name and Address of Party claiming damage against you

Is the Injury or Damage related to a travelling companion?

Yes No

Do you consider you were at fault? (If so, why)

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RENTAL VEHICLE COLLISION AND THEFT EXCESS COVER CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The Rental Agreement.
2. Notice from the Rental Company in respect of the excess or deductible.
3. Documentation evidencing payment of excess or deductible.
4. A copy of the Rental Vehicle Repair Invoice from the Hire Company.

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

Date Of Loss

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

Privacy Consent - Claim Assessment

Protection of My Privacy Acknowledgement and Consents

By signing this form I agree that ACE Insurance Limited ABN 23 001 642 020 ('ACE') and third parties such as my insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by ACE, my employers (past and present), my accountant, any business which provides information about the commercial activities of persons and if I am or have been bankrupt, the trustee of my estate ('the Parties') may exchange with each other any information about me, excluding health or other sensitive information, including:

- Any information provided by me in relation to my claim;
- Any other personal information I provide to any of them or which they otherwise lawfully obtain about me;
- Any information relating to this insurance or any other insurance held by me or on my life, including terms and conditions and claims history;
- Details of my employment, including position, period of employment, remuneration, hours worked and duties performed; and
- Any information relating to my income and solvency.

I agree that any information referred to above can be used by the Parties and any Service Provider (as identified below) for assessing the claim or my entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

I agree that ACE may exchange my personal and/or sensitive information, for the purposes of assessing the claim or my entitlement to benefits with:

- Any investigator appointed by ACE to investigate the claim;
- The Health Record Holders;
- The Health Insurance Commission;
- Other insurers;
- Reinsurers;
- Any private or government organisation which investigates fraud including the police; and
- Any witness identified by me.

If I have identified any person as a witness, I agree to ensure that each person is made aware that:

- I have identified him/her as a witness in relation to the claim;
- ACE holds a record of their personal information for this purpose; and
- He/she may contact ACE or request access to his/her information, by calling 1800 815 675.

If ACE engage anyone (a 'Service Provider') to do something on its behalf (for example technology providers) then I agree to them exchanging any information referred to above, with each other.

I understand ACE might give any information referred to above to entities other than the Parties, the Service Providers, the Health Record Holders and the other persons/organisations referred to above where it is required or allowed by law or where I have otherwise consented.

I understand that I can access** most personal information that members of ACE Insurance Limited hold about me (sometimes there will be a reason why that is not possible, in which case I will be told why).

I understand that if I fail to provide any information requested in this form, or do not agree to any of the possible exchanges or uses detailed above, ACE may be unable to assess the claim.

** To find out what sort of personal information ACE have about you, or to make a request for access, please telephone 1800 815 675.

Medical Authority, Declaration and Power of Attorney

I DECLARE THAT,

- I will use my best endeavours and render all reasonable assistance and co-operation to Ace Insurance Limited (ACE) in the assessment of my claim;
- the information supplied by me is true and correct and that I have not withheld any information likely to affect the acceptance of the claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I hereby appoint ACE to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I hereby authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as ACE in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);
- my Health Insurance claims history, including Medicare;
- any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

Signature of Claimant

Date

Signature of Witness

Date

