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Travel Insurance Claim Form

The issue of this form is not an admission of liability

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

CLAIMANT DETAILS	
Policyholder's Name/s:	
Policy Number:	**Annual Cover Level:**
Name of Claimant (Mr/Mrs/Miss/Ms) (Sick or Injured traveller, property owner)	
Occupation:	**Date of Birth:**
Address:	
State:	**Post Code:**
Telephone – Home:	**Mobile:**
Email:	

TRAVEL INFORMATION	
Date of Departure: / /	**Scheduled return date: / /**
When was the trip booked: / /	
Departure Country:	**Departure City:**
Destination Country:	**Destination City:**

PAYEE'S BANK DETAILS

Once the claim is assessed and approved, any settlement payable will be credited direct to your Bank Account.

Please complete the following:

Bank: _____

Account Holder's Name(s):_____

BSB Number: _____

Account Number: _____

SWIFT CODE (For Non Australian banks only):_____

Claim Lodgement

To lodge your claim, email the completed claim form along with the necessary supporting documentation to ahclaims@proclaim.com.au or to the postal address at the top of this form.
We recommend you keep a copy of all documents sent by post

Travel Insurance Claim Form

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

THE FOLLOWING QUESTIONS MUST BE ANSWERED FOR ALL CLAIMS / ALL SECTIONS

Give full details of how loss, damage, theft or incident occurred. Detail each event as specifically as you can including circumstances leading up to and following the incident.

Date of occurrence ...../...../..... Time ..... am/pm

Date loss reported ...../...../..... Time ..... am/pm

Loss reported to – Name .....

Address.....

REFER NOW TO THE SECTION/S THAT ARE RELEVANT TO YOUR CLAIM – Note sections may not be in chronological order – Be sure to SIGN YOUR CLAIM FORM ON PAGE 8

SECTION 1 – CANCELLATION & DISRUPTION

What was the reason you could not commence / continue your planned journey?

* If the cancellation was a result of an Injury or Sickness to either yourself or to a Relative or other person (as defined) then **please also complete Section 2** with details of the medical condition and ensure that **the treating doctor completes the *Medical Certificate*** attached to this claim form – refer to page 9.

Date you cancelled or advised your Travel Agent or airline to cancel your bookings ...../...../.....

Amount of Deposit paid and date paid $ ..... Date .....

Balance of Full Fare and date paid $ ..... Date .....

TOTAL PAID $ .....

Refund received on cancellation $ .....

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

.....

Continues overleaf

SECTION 1 – CANCELLATION & DISRUPTION - Continued

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

……

……

Details of expenses incurred

	A$
	A$
	A$
	A$
TOTAL	A$

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM *

1. A copy of the original planned itinerary;
2. Invoices, Itineraries and/or Tickets relating to additional expenses incurred;
3. Evidence of refunds payable or that fare/accommodation is not refundable
4. Proof of cause i.e. The completed Medical Certificate (refer to Page 9 of this document) or letter/email from airline/provider relating to reason for cancellation, curtailment or diversion of scheduled 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:

……

……

SECTION 2 – EMERGENCY MEDICAL, REPATRIATION & OTHER EXPENSES

Full Name of person whose Injury, Sickness or Death resulted in the expenses claimed:		
Relationship of person above to the Policy Holder and/or claimant:		
Date of Accident or onset of Sickness		
What was the Diagnosis (Nature of the Injury or Sickness):-		
If Injury – Give full details of Accident		
If Sickness – Describe the onset of symptoms:-		
When did you first seek Medical attention?		
Name of Doctor or Hospital first attended?		
Were you admitted to hospital?	Admitted / / am/pm	Discharged / / am/pm
Give details of treatment including surgery:		

Continues overleaf

SECTION 2 – EMERGENCY MEDICAL, REPATRIATION & OTHER EXPENSES – Continued

Have you ever suffered from the same or a similar medical condition in the past? Yes / No

Yes, give details, dates, etc.	

UNLESS THE MEDICAL EMERGENCY ASSISTANCE PROVIDER WAS CONTACTED AT THE TIME OF YOUR ADMISSION TO HOSPITAL, THE FOLLOWING ITEMS MUST BE INCLUDED WITH YOUR CLAIM FORM:-

1. Itemised invoices from all Doctors and Hospitals and other providers;
2. A Doctor's Certificate or Medical Report confirming the diagnosis, date of onset and treatment or completion of the attached **Medical Certificate** part of the claim form **- Refer to page 9**.

*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:

……

……

……

SECTIONS 4 & 5 – BAGGAGE & DELAYED BAGGAGE and MONEY, TRAVEL DOCUMENTS & CREDIT CARDS

Date, time and place that the property was last seen and known to be undamaged:- ……

Place where in your opinion the loss, damage or theft occurred: ……

Were articles lost by or damaged whilst in the care of Carrier? (e.g. Airline) Yes / No

If yes, Name of responsible Carrier:- ……

NOTE: The Warsaw Convention imposes a liability upon the Carrier so you must firstly lodge a claim or complaint against any Carrier/Airline or other authority or against any individual responsible for the loss or damage to your property before lodging this claim. You should then include details and attach copies of correspondence.

Who do you consider responsible for the loss or damage & why:- ……

Were the items securely stored and if so how was access/entry made? ……

Are any of the items covered by other Insurance? Yes / No

If yes – which Company? ……

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:- ……

……

Continues overleaf

SECTIONS 4 & 5 – BAGGAGE & and MONEY, etc - Continued

What action has been taken to recover the lost property:-

……

……

……

Have you previously claimed for the theft, loss, damage to personal items and valuables and if so, please provide brief details about the loss including how, where, approximately when and the value of the loss: ……

……

All theft claims and all claims against Section 5 must be reported to Police.

Date notified…….. To whom……

Address of Police Station: ……

Attach copy of the Police Report (or if within Australia, the crime report number).

Item Claimed – include details make & model, description of items If no proof of ownership is available please explain how you came to own the item, approximate age of the item and general condition.	**Amount Claimed (AUD)**

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. For theft claims, a report or letter from the relevant Authority (e.g. Police, Airline).
2. Proof of purchase of lost goods (e.g. Receipts, Guarantee or Valuation Certificates, Card Vouchers, etc.)
3. 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.

SECTION 3 – ACCIDENTAL DEATH & OTHER PERSONAL ACCIDENT

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of the Death Certificate;
2. Copy of Coroner's letter stating Cause of Death unless stated on the Death Certificate;
3. Copy of Coroner's Depositions and Findings (if applicable)
4. Copy of original Birth Certificate.

For other Personal Accident Benefits please provide Hospital Discharge Summaries, copies of x-rays and scans and any other documentation available which details the nature and extent of the Injury.

When did the accident occur?	/ /	Time am/pm

Please detail how the accident occurred	

SECTION 9 – YACHT CHARTER EXCESS WAIVER

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The Car Hire or Yacht Charter Agreement.
2. Notice from the Hire or Charter Company in respect of the Excess or Deductible.
3. Documentation evidencing payment of excess or deductible.
4. A copy of the Car or Yacht repair invoice/s from the Hire/Charter Company.

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

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

Date of Event: / / Time:
Description of accident & the damage sustained:
Who do you consider was responsible for the damage:
Did you report the damage to Police?
Address of Station:
If no, state why not:
What action was taken to prevent or minimise the damage (as applicable):
Have you previously made a claim for damage to a yacht/motorboat? Yes ☐ No ☐
If yes, provide details:-

SECTION 8 – WINTER SPORTS

Reason for cancellation or loss of Passes: Injury ☐ Loss or Theft ☐ Other ☐

If Other, please provide details:	

	Ski Pass	Ski Equipment Hire	Ski Tuition Fee
Cost (AUD unless specified)			
Start Date			
End Date			
Number Days Los			

SECTION 6 – LEGAL EXPENSES & PERSONAL LIABILITY

Date of Event	DD / MM/20__ at am/pm or between am/pm and am/pm
Where did the event occur?	
Brief Description (including cause of loss or damage)	…… …… …… ……
Amount claimed	$
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 & email or telephone number of third party(ies))* …… ……

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PRIVACY STATEMENT

Certain Underwriters at Lloyds and 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 on behalf of Certain Underwriters at Lloyds. We may need to provide that information to the underwriters at Topsail Insurance 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.

When the claim relates to my medical health **I authorise** any hospital, physician or other person who has attended me to furnish the claims managers, Proclaim, with any and all information with respect to related medical history, consultations, 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 other insurer, any travel agent or airline or provider of similar services 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.

Your Signature: **Date: / /**

Print Your Name:

Proclaim

Travel Medical Certificate

This Medical Certificate must be completed by the ill/injured/deceased person's **usual Doctor (General Practitioner)** and not any Specialist Doctor he/she may attend. The Medical Attendant is respectfully requested to be as detailed as possible in order to assist the claimant and avoid the necessity of additional enquiries. **The Claimant must obtain this document at his/her own expense.**

Patient Details – Person to whom this Certificate applies

Family name:	Date of birth: / /
Given names:	

Are you his/her regular medical attendant? No ☐ Yes ☐ If yes, for how long? _____

If No, please indicate in what capacity you attended the patient and for how long?

Injury or Sickness Details or Cause of Death

a) Precise nature of Illness / Injury / Death: _____

_____

b) Date of Injury or Onset of Illness: _____/_____/_____

c) Details of patient's state of health and medical condition on the date his/her travel insurance was effected? _____

_____

d) Bearing in mind your response to c) above, was it reasonable for the claimant to continue with their travel plans? Yes ☐ No ☐

e) If applicable, date when there was deterioration in the condition affecting capacity for travel? _____/_____/_____

f) Date when it first became apparent the claimant would be unable to travel? _____/_____/_____

g) When did you advise your patient of the need to cancel or postpone their travel plans? _____/_____/_____

h) Has the patient previously suffered or received treatment, advice or medication for the same or any related or similar conditions? Yes ☐ No ☐

If yes, please provide details including dates:- _____

_____

i) Was the patient waitlisted for public hospital admission?
If so, what date was the referral sent to the public hospital? _____/_____/_____

j) If pregnancy, stated E.D.D. and reason for cancellation advice

_____

k) Are you prepared to certify that solely due to the condition described above the Claimant is compelled to cancel or postpone their travel plans? Yes ☐ No ☐

G. Doctor's details – Please complete or stamp

Doctor's name: _____ Qualification: _____

Address: _____

Email: _____ Signed: _____

Phone: _____ Completion Date: / /