Claim Form (A) July 2007

1. Medical And Dental 2. Additional Expenses
3. Travel Delay 4. Amendment Or Cancellation Costs

Claim Form (B) is for Luggage, Money, Delayed Luggage or Rental Car Insurance Excess Claims

NOTE: For all claims relating to sections of this policy not listed above, complete page 1 of this claim form and attach a letter summarising your claim.

Cover•More Travel Insurance

P.O Box 105-203, Auckland City
AUCKLAND 1143
Ph: 0800 600 115

- Please ensure you provide all requested information and documentation. If you need help with your claim please telephone us. If you don't provide what is required your claim may be delayed or not paid.
- Please keep a copy of your claim.
- We shall respond to your claim within ten business days from the day we receive it.

COMPLETE THIS PAGE FOR ALL CLAIMS

YOUR DETAILS

Please tick preferred option for correspondence
☐ Email ☐ Post

Title | Given name/s

Family name | Date of birth

Email address

Postal address

Suburb/City

Postcode | Home phone ( )

Mobile | Work phone ( )

Policy number | Name of Travel Agency

A copy of your Certificate of Insurance must be attached ☐ Attached

Date arrangements booked

Date departed | Date returned

Have you ever made a Travel Insurance claim in the past? ☐ Yes ☐ No
If yes, please give details (including name of insurer):

Certain credit cards may provide basic travel insurance cover which may also cover your loss. Do you have credit card/s? ☐ Yes ☐ No
If yes, please state:

Provider | Type

Did you purchase your travel on the card/s? ☐ Yes ☐ No

Can you claim/have you claimed through any other source? (e.g. private health fund, transport provider, third party etc.) ☐ Yes ☐ No

Details

WARNING

To avoid passing the costs of dishonest and fraudulent claims on to you, our honest policyholder, we are strongly committed to investigating claims. We try to conduct/finalise investigations quickly and with minimal disruption. All cases of fraud will be reported to the Police and can result in imprisonment.

BANK DETAILS

If your claim is approved and cash settlement made we will deposit the amount payable directly to an account you nominate (we cannot deposit into a credit card account). Please provide account details below.

Bank/Branch No. | Account No.

Suffix

YOUR DECLARATION

I declare that all information contained on this claim form is/will be true and correct. I acknowledge that my personal information may be disclosed to, and obtained from, certain other parties as detailed in your policy brochure.

Signature of Policyholder | Date

PLEASE COMPLETE THE FOLLOWING FOR ALL CLAIMS

Date of incident | Time AM/PM | Country | Location

Cause of claim (include details of any illness/injury and if an injury please explain how the injury occurred). Please attach a letter if more space is required.

1. If your claim is due to someone's state of health:
   a) Surname of person | First name | Date of birth | Relationship of person to you

   b) Has the illness/injury occurred before? ☐ Yes ☐ No If Yes, give details including approximate dates

MEDICAL AUTHORITY: To be completed by the person whose state of health caused the claim or the Executor of the Estate, if applicable

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for the condition/s which resulted in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original.

Signature of Patient/Executor of the Estate

Print name

Name of usual doctor or dentist in New Zealand (whichever is applicable)

Doctor's or dentist's phone number ( )

Doctor's or dentist's fax number ( )

Doctor's or dentist's email or postal address (include postcode)

FROM THIS POINT FOWARD – ONLY COMPLETE THE SECTIONS RELEVANT TO YOUR CLAIM

NOTE: For all claims relating to sections of this policy not listed above, complete page 1 of this claim form and attach a letter summarising your claim.

1. MEDICAL & DENTAL EXPENSES

Please ensure that you attach the following documents: Attached ☑

- Original (not photocopy), itemised account/s ☐
- Original medical report/dental report/hospital records confirming the nature of the illness or injury ☐

Please list each bill/receipt separately:

Name of doctor/dentist, pharmacy, hospital or provider	Date of treatment, consultation etc.	Amount charged (include currency)	Paid?	OFFICE USE ONLY
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	
			☐ Yes ☐ No	

Please attach a list if more space required.

2. ADDITIONAL EXPENSES BENEFIT (after departure)

Please ensure that you attach the following documents: Attached ☑

- Original (not photocopy), itemised hotel accommodation accounts, transport tickets and receipts for what is being claimed ☐
- A copy of your itinerary ☐
- If your plans changed due to a policy holder's health, a medical certificate from the medical practitioner consulted (whilst on the journey) confirming the need to change your plans ☐

1. What were the unexpected costs incurred?			**2.** If the event had not happened, how much did you expect to pay for transport/accommodation for the corresponding period?			**3.** Deduct 2 from 1 and write amount here. This is the maximum amount you can claim under this policy section
Description of cost	Cost (state currency)		Description of cost	Cost * (state currency)		
eg *hotel in Paris 27/5/06*	*100 Euro*	-	*hotel in Milan 27/5/06*	*75 Euro*	=	*25 Euro*
		-			=	
		-			=	
		-			=	
		-			=	

* If the amount shown was prepaid and you are not entitled to a full refund from the service supplier you should submit a claim for the non-refundable portion under the Cancellation section on page 3

3. TRAVEL DELAY

Please ensure that you attach the following documents: Attached ☑

- Written confirmation from the Transport Provider of the cause and period of the delay and the amount of compensation offered by them ☐
- Original, itemised receipts for the hotel expenses claimed ☐
- Documentary evidence from your travel agent which confirms the amount refunded for the unused accommodation ☐

When were you due to depart? Date Time AM/PM

When did you actually depart? Date Time AM/PM

1. What was the unexpected hotel cost incurred?			**2.** What is the refundable amount for the accommodation you prepaid in advance (which you would have stayed in on this night if your transport wasn't delayed)?			**3.** Deduct 2 from 1 and write this amount here. This is the maximum amount you can claim
Description of cost	Cost (state currency)		Description of cost	Refundable amount		
eg *hotel in Paris 27/5/06*	*100 Euro*	-	*hotel in Milan 27/5/06*	*75 Euro*	=	*25 Euro*
		-			=	

4. AMENDMENT OR CANCELLATION COSTS

To be completed by your travel agent:

Documents needed to process your client's claim: Attached

- International flights: A copy of the airline fare sheet/rules (showing the fare conditions) ☐
- For tours, cruises, accomodation etc: a document from the supplier showing the exact amount refundable e.g copy of booking conditions, letter from the supplier ☐
- A copy of the original itemised invoice you provided to the customer ☐
- A copy of the itinerary ☐
- If the claim is due to someone's health, the medical certificate on page 4 must be completed by their usual medical practitioner ☐

	Name of supplier	Cancellation costs: Gross amount paid		Net amount refunded by supplier		Cancellation costs	OR	Amendment costs
Flights (excluding taxes)			-		=			
			-		=			
			-		=			
Flight Taxes			-	Fully refundable by the airline	=	$0		
Accommodation			-		=			
			-		=			
			-		=			
Packages			-		=			
			-		=			
			-		=			
Other (i.e. car hire, rail passes, etc.)			-		=			
			-		=			
			-		=			

Total Amendment/Cancellation Costs $ (A)

If the trip was cancelled outright prior to departure what would it have cost to amend the trip to different dates (rather than cancel outright)? $ (B)

I certify that the information stated on this form is true and correct.

Consultant's name

Consultant's signature

Agency name and address

Date

Phone ( )

Fax ( )

Email

To be completed by you:

1. On what date did you amend/cancel the trip?

2. Did you cancel the whole trip prior to departure?
   - ☐ Yes (go to question 3)
   - ☐ No (you do not have to answer question 3 or 4)

3. Is (B) (above) less than (A)?
   - ☐ Yes (go to question 4)
   - ☐ No (you do not have to answer question 4)

4. It appears that if you had amended your trip to different dates it would have cost less than cancelling your trip. Why were you unable to travel on different dates?

MEDICAL CERTIFICATE - To be obtained at your expense from the patient's usual doctor in all cases of Amendment or Cancellation Costs resulting from injury, 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.

PLEASE USE BLOCK LETTERS

1. Name of patient
Date of birth

2. Are you the patient's usual G.P.? ☐ Yes ☐ No
If Yes, for how long?
If No, please provide full details of the patient's usual G.P.

3 a) Please give a precise diagnosis of the illness or injury

b) On what date did the patient first consult you with symptoms of this condition?

4. Date of onset of illness or injury

5. Date tests prescribed

6. Date tests carried out

7. Date results advised to patient

8. Date referred to specialist

9. Name and address of specialist/surgeon

10. If due to a pregnancy:
a) On what date was the pregnancy confirmed?
b) How many weeks pregnant was the person on this date?
c) Was the conception medically assisted? ☐ Yes ☐ No
d) Have there been previous complications with this or any other pregnancy? ☐ Yes ☐ No

11. Have you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in question 3a? ☐ Yes ☐ No
If Yes, a) State the diagnosis of the previous illness/injury

b) Advise the date of occurrence of the previous illness/injury and advise what treatment/medication was prescribed

c) Is the patient receiving any regular advice, treatment or medication for this condition or any similar/related condition? If so please give details

d) Was the patient hospitalised? ☐ Yes ☐ No If Yes, advise admission date

12. Has any other Doctor treated this patient for the same/similar/related illness or injury? ☐ Yes ☐ No
If Yes, please supply the name and address of the Doctor

13. Are you prepared to certify that solely due to the condition described in question 3a, the claimant/s was/were required to cancel or curtail the travel arrangements? ☐ Yes ☐ No

THE FOLLOWING QUESTIONS ONLY APPLY IF THE PATIENT WAS IN THE TRAVELLING PARTY

14. How long was or will the patient be prevented from travelling? From To

15. Had the patient planned to travel against your prior advice? ☐ Yes ☐ No
If **Yes**, please give details

I certify that the statements contained in this Medical Certificate are true and correct

Doctor's Signature
Name
Date

Qualification
Telephone

Email address, fax number or postal address

CVM366 - 07/07