

# Expatriate Medical Expenses

## Claim Form

### Important Information

Please ensure that all relevant sections of this claim form are fully completed. We are unable to consider assessment of your claim unless all information has been given. Failure to complete all information may result in delay in the assessment of your claim.

- The issue and acceptance of this Form does not constitute an admission of liability by the Company or a waiver of its rights.
- Each individual is to complete a **separate** claim relating to their expenses.

It is important you provide honest, complete, up-to-date and relevant information when completing this form.

Section 1: Policy and Claimant Details			
Insured Company			
Policy Number			
Employee's Name			
Email			
Employee's Address			
Patient's Name		Relationship with Employee	
Patient's Nationality			
Is the patient entitled to Accident Compensation Corporation (ACC) benefits in New Zealand (for injury related claims)?			<input type="checkbox"/> Yes <input type="checkbox"/> No
Does the patient hold Private Health Insurance?			<input type="checkbox"/> Yes <input type="checkbox"/> No

Section 2: Electronic Funds Transfer Details			
Following Chubb approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:			
New Zealand Bank Account Details			
Name of Financial Institution		Account Holder's Name	
BSB Number		Account Number	
Bank Address			
Overseas Account Details			
Name of Financial Institution		Account Holder's Name	
BSB Number/Routing Code/ABA Number/IBAN		Account Number	
Bank Address			
Currency for Refund		SWIFT Code	

### Section 3: Overseas Medical and Dental Details of Amounts Claimed

Date of Service	Injury/Illness (e.g. sprained ankle)	Fully Describe Procedure, Medical Services, Supplies Furnished (e.g. x-ray, plaster, doctor consultation, physiotherapy, etc.)				Charges (\$A or other currency)

(Attach all relevant documentation and receipts)

Date	Physicians or Providers	Address

### Section 4: Hospitalisation Only Benefit Claim

Type of Injury or Sickness

Date of Accident or commencement of Sickness      /      /

If Injury - Give full details of Accident. If Sickness, give details of onset of condition

Date of First Medical Consultation      /      /      Name of Doctor or Hospital

Details of other treatment by Doctors/Hospital

Dates in Hospital:    Admitted      /      /      time      am/pm    Discharged      /      /      time      am/pm

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

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

Date	Physicians or Providers	Address

## Section 5/6: Additional Expenses, Loss of Deposits and Cancellation Charges

The following documents are required for us to process your claim:

1. Any document that satisfies us that travel has been booked, e.g., a confirmed itinerary or travel agent invoice or boarding pass
2. Any document that supports the unforeseen circumstances that led to the cancellation, e.g., a medical certificate if on medical grounds
3. Any document that adequately supports the amount claimed

\*Failure to provide these documents may result in processing delays.

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 YES - Name			
Address			
Relationship		Age	

What was the nature of complaint preventing travel?			
Date of first medical treatment		Has the injured/sick person had a similar condition in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES, name and address of patient's normal doctor?			

Date of cancellation of travel bookings			
Amount of deposit paid and date paid		Date	
Balance of full fare and date paid		Date	
Value of forfeited portion of journey (if applicable)			
Have you attempted to obtain a refund?			<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES - Name of organisation (e.g. airline, travel agents, etc)			
Contact phone number			
Email address			
Refund received on cancellation			
Full amount being claimed			

## Section 7/8: Luggage, Travel Documents and Replacement of Money

The following documents are required for us to process your claim:

1. Any document that satisfies us that travel has occurred, e.g., a confirmed itinerary or travel agent invoice or boarding pass
2. Any document that demonstrates proof of ownership
3. Any document that adequately supports the amount claimed, e.g., replacement invoices or repair quotes
4. Police report in the event of theft

**\*Failure to provide these documents may result in processing delays.**

Please provide details of how losses, damages or thefts occurred:

Date of loss/damage/theft		Time	
Date of loss/damage/theft		Time	
Date of loss/damage/theft		Time	

Loss/damage/theft reported to - (police, transport provider or other authority)

Were the articles lost/damaged by a carrier? (e.g. airline)	<input type="checkbox"/> Yes <input type="checkbox"/> No	If YES, name of carrier	
Have you lodged a claim or complaint to any carrier/ airline or other authority or against any individual responsible for the loss or damage to your property? If YES, give name and reference number:	Name		Reference Number

If NO, you should proceed to claim with your airline/carrier before submitting your claim to Chubb

If the items were lost, what action was taken to recover them?

Are any of the items covered by other insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No
If YES - which company	Policy Number

Were all the missing articles owned by you?  Yes  No

If not, please provide details

Description of damaged/ lost/stolen items	Name and address from whom goods were purchased	Date of Purchase	Original purchase price	Depreciation deduction	Amount received from other source	Amount claimed

**Section 9: Rental Vehicle Excess**

**The following documents are required for us to process your claim:**

1. Any document that satisfies us that travel has occurred, e.g., a confirmed itinerary or travel agent invoice or boarding pass
2. Any document that demonstrates that the car was hired, e.g., vehicle rental agreement
3. Any document that shows proof of cost, e.g., quote or invoice for repairs

**\*Failure to provide these documents may result in processing delays.**

Date of collision or theft	
Amount of excess	

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

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**Section 10: Travel Delay**

**The following documents are required for us to process your claim:**

1. Any document that satisfies us that travel has occurred, e.g., a confirmed itinerary or travel agent invoice or boarding pass
2. Notification from the transport carrier confirming the reason for the delay
3. Proof of additional expenses, e.g., receipt/invoice

**\*Failure to provide these documents may result in processing delays.**

Scheduled flight or other transport no.		Departure airport or station	
Scheduled departure time		Actual departure time	
Alternative onward flight or other transport no.		Date and departure time	
Date(s) expenses incurred			

List the country and the currency of the country in which you incurred the costs

Country:		Currency:	
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List specifically the additional expenses

Details	Country Incurred	Currency	Amount	Date Incurred

## Section 11: Personal Liability

The following documents are required for us to process your claim:

1. Letters or Demands of a claim made against you

**\*Failure to provide these documents may result in processing delays.**

Is the claim for bodily injury or death?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If YES, Name of injured or deceased party	
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Address of injured or deceased party	
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Details of injury or death	
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If NO, List of damaged property	
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Name of person claiming against you	
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Address of person claiming against you	
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Is the injury or damage related to a travelling companion?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If YES, please provide details	
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Have you in any way admitted liability?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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If YES, please provide details	
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Do you consider yourself at fault?	<input type="checkbox"/> Yes <input type="checkbox"/> No
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Why or why not?	
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## Chubb Insurance New Zealand Limited Claim Privacy Consent, Medical Authority and Declaration

### Claim Privacy Consent

Chubb Insurance New Zealand Limited (Chubb) collects, uses and retains your personal information only in accordance with the principles in the *Privacy Act 1993*.

A copy of our Privacy Statement, which expands upon our privacy obligations and provides further information on your rights to access your personal information held by us is available on our website or by contacting our Privacy Officer on +64 (9) 377 1459.

Your personal information will be used by Chubb, or any third party that Chubb provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim or any associated complaint and for planning, product development and research purposes.

Your personal information includes:

- a) any information provided in relation to your claim or any associated complaint;
- b) any information that is health information or sensitive information;
- c) any other personal information that you may provide to Chubb or its third party contractors;
- d) any information relating to the insurance policy on your life, including terms and conditions and claims history;
- e) details of your employment including position, period of employment, remuneration, hours worked and duties performed; and
- f) any other information relating to your income and solvency.

To process your claim Chubb may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by Chubb, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the Parties). You agree that the Parties may disclose your personal information to Chubb.

Chubb may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies within the Chubb Group, other insurers, our reinsurers, and government agencies (where we are compelled to by law). These third parties may be located outside New Zealand. Chubb may also disclose your personal information to witnesses in respect to your claim.

You agree to us using and disclosing your personal information pursuant to Chubb's Privacy Statement and this Claim Privacy Consent. In the event of any conflict between the documents, this Claims Privacy Consent shall be determinative. This consent remains valid unless you alter or revoke it by giving written notice to our privacy officer.

If you do not consent to the terms of this Claims Privacy Consent or revoke your consent, Chubb may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our Privacy Officer on +64 (9) 377 1459 or email [Privacy.NZ@chubb.com](mailto:Privacy.NZ@chubb.com).

### Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, Chubb has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Chubb using and disclosing my personal information pursuant to Chubb's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Chubb's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to Chubb such personal information (including health information) as Chubb in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to Chubb in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim. I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint Chubb to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of claimant		Date	/ /
Name of claimant			
Signature of Witness		Date	/ /
Name of Witness			

**To Be Completed by Representative of the Insured for all Expatriate and Inpatriate Claims and Submitted with First Claim**

I, (Company Representative)			
confirm that (Insured Person)			
is an employee of			
and that he/she is a Nominated Expatriate/Inpatriate with effect from		/ /	
Cover (please tick) <input type="checkbox"/> Family <input type="checkbox"/> Couple <input type="checkbox"/> Single			
Signature		Name	
Title		Contact Number	
Claim Reference (if known)			
Policy Number (if known)			

**Contact Us**

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