Leisure Travel
Claim Form

Please complete and sign and return to AIG, PO Box 1745, Shortland Street, Auckland 1140

Policyholder Details

Full Policy No

Telephone – Day [ ] After hours [ ]

Name of Traveller/s (Mr/Mrs/Miss/Ms)

Address

Email Occupation

Date of Birth / /

Credit Card (circle) Gold / Platinum / Titanium Card Number

Issued by which bank?

On what date did you pay for this travel on your card? / /

Period of Journey: Total Number of Days: From / / to / /

Purpose of Your travel (Please circle) Leisure Only / Business Only / Leisure and Business please give details

Cancellation / Additional Expenses

Cancellation of journey:

Please give reason

Date you advised Travel Agent to cancel bookings (if applicable) / / Date of Incident causing Loss / /

If cancellation costs or additional expenses were incurred due to Injury/Sickness:

Name of person Relationship to You

Address Age

Describe the Injury/Illness

Date of First Treatment / / Has the patient EVER had a similar condition before? YES / NO

Patients Usual Doctor Name; Address & phone number

Amount of Deposit paid $ Date Paid / /

Balance of Full Fare paid $ Date Paid / /

TOTAL PAID $

LESS Refund on cancellation $ Date Received / /

Were any additional fares incurred as a result of cancellation YES / NO Give details

Were any alternative arrangements sought by You or alternative offers made? YES / NO Give details

Reason for incurring additional expenses or forfeiting travel or Accommodation expenses

Details of expenses incurred (attach list if required) **Description of Item**	**Cost NZ$**
TOTAL	**NZ$**

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Original Receipts and/or Tickets relating to loss of deposits or additional expenses incurred
- Substantiation i.e. Original Doctor/Hospitals Certificate relating to Injured or Sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport.
- Copy of your gold card statement showing payment dates of travel and accommodation

Luggage and Personal Effects

Add sheet if insufficient space

Give full details of how loss, damage or theft occurred:

Date of occurrence / / at AM / PM

Date loss reported / / at AM / PM

Location of Loss

Name of Authority Loss reported to:

Were articles lost by Carrier? (eg Airline) YES / NO Carrier Name

Have You made a claim yet? YES / NO Claim No

NOTE: The Montreal Convention imposes a liability upon the Carrier and you should claim on them first.

Have you lodged a complaint against any other authority or against any individual responsible for the loss or damage to your property? YES / NO

If so, give details and **attach copies of correspondence**

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 not, who is the owner?

Give a full description of type and size of suitcase or bag in which missing goods were carried

Full details of articles claimed (include value of cases)	Name and address of supplier from whom goods were purchased	Date of Purchase	Purchase Price	Deduction for Deprec.	Amount Claimed	Remarks

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Report or letter from Authority (e.g. Police, Airline) regarding the loss, where available.
2. Proof of **original** purchase of lost goods (e.g. Receipts, Guarantee or Valuation Certificates, Card Vouchers, etc.)
3. Please attach ALSO, any receipts for items which You have replaced already.

Medical Expenses or Cash in Hospital

Date of Accident or Date Symptoms of Sickness First Appeared / /

Where were you? Place: Town/City: Country

Give full details of Injury or Illness

Have you Lodged a claim with ACC? YES / NO ACC claim number

Date of First Medical Consultation / /

Name & Address of Doctor or Hospital

Name & Address of any other Doctor/s or Hospital/s who treated you

Hospital:

Admitted / / AM / PM Discharged / / AM / PM

Have you EVER suffered from the same or a similar complaint in the past? YES / NO

If Yes, give details, dates, duration etc.

NB. If you are a member of a Private Health fund you must claim from that fund before submitting this claim.

Are you a member of a Private Health Insurance fund e.g. Southern Cross YES / NO

Name of Insurer

Details of expenses incurred (attach list if required) **Description of Item**	**Cost NZ$**
TOTAL	NZ$

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Original Doctors/Hospital accounts and receipts together with statements from your Private Health Insurer/ACC details.
2. Original Doctors Certificate.

Personal Money

Date of Loss / / Place of Loss

Date Notified / / Which Police Station was advised?

Amount Claimed $ (Attach copy report if available)

Description of the incident

Personal Liability

Date of Incident ___/___/___

Bodily Injury

Name and Address of Injured Party

Details of Injury

Is the Injury or Damage related to a travelling companion? YES / NO

Is this person related to You? YES / NO Give Details

Damage to Third Party Property

Name and Address of Party claiming against You

Describe Property Damage

Do you consider you were at fault? YES / NO (If yes, why)

Letters or Demands (including Rental Agreement and Damage Reports where applicable) of a claim made on you Must Be Included With This Claim

Payment

Option 1: Direct credit to NZ bank account. Please complete bank details and account number below

OFFICE USE
Bank a/c checked

Option 2 Overseas Bank Transfer

Bank Branch Country

Account details

AIG no longer issues cheques. To confirm transfer of funds, an auto email will be sent to your broker or direct

Email: Broker/Payee

Payee Signature

Payee Name

Declaration; Authority & Privacy Consent

Insured Traveller Must Sign Below

I/we (print name/s) Print Name

declare that the above answers and those contained in any attachments are true and note that the Insurer may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to provide AIG Insurance New Zealand Limited ('AIG') with assistance in dealing with this matter and understand that failure to co-operate with AIG and to provide all information relevant to the circumstance may result in my/our claim being denied.

AUTHORITY:

I/we authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish AIG or its representatives with:

I. copies of hospital and medical reports/notes;

II. copies of employment records and income tax returns; to the extent that they are relevant to the claim and

III. information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

I/we agree that a photocopy of this authorisation shall be considered as effective and valid as the original and authorise its use as such.

PRIVACY:

I/we consent to AIG in accordance with the Privacy Act 1993:

1. collecting holding and using personal information including information by audio, photographic or video surveillance, provided for purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
2. disclosing personal information submitted to another AIG company, its staff members, the insured, other insurers and re-insurers, law enforcement agencies, investigators, lawyers, assessors, advisors and the agent of any of these, insurance broker, insurance agent or intermediary, employer for the purpose of administering my claim or providing a report.

Information is provided voluntarily however if we do not collect this information we may not be able to assess a claim. Insured persons have rights of access and correction to their personal information under the Privacy Act. Further information about this or making a privacy complaint can be obtained by emailing : Privacy.officerNZ@aig.com

NOTE: AIG will only seek information which in its opinion it believes to be relevant to investigation of the claim I/we consent to AIG' assistance provider, Travel Guard, recording of all calls to the assistance service provided under the Travel Insurance for quality assurance, training and verification purposes.

Signature /s of Insured person/s: Signature Date / /

If you are signing on behalf of the Insured person please state your authority to do so and relationship. Please complete:

Name Name Phone [ ]

Position of Authority to sign – Nature of Relationship

- **You will need to attach substantiating documents as specified in this claim form.**
- **Failure to provide substantiating items may result in delays in processing your claim – if it is impossible to provide any of the items required please advise the reason.**
- **The issue of this form is not an admission of liability and is without prejudice**

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