TRAVEL INSURANCE
CLAIM FORM

THIS FORM HAS BEEN DESIGNED FOR BOTH INTERNATIONAL AND DOMESTIC INSURANCE CLAIMS. SOME SECTIONS MAY NOT BE RELEVANT TO THE INSURANCE YOU HAVE PURCHASED. THE FRONT PAGE AND DECLARATION ON THE FINAL PAGE MUST BE FULLY COMPLETED IN ALL INSTANCES.

Please indicate claim type INTERNATIONAL CLAIM ☐ DOMESTIC CLAIM ☐

CLIENT DETAILS

Insured name | Title | Date of birth / /

Address

Postcode

Private telephone (0) | Business telephone (0)

E-mail

Occupation

Name of agent who arranged travel

Name of agent who arranged insurance

Insurance certificate number | Please attach your insurance certificate to the claim form

ALL DOMESTIC CLAIMS MUST INCLUDE A FULL COPY OF YOUR AIRLINE ELECTRONIC TICKETS AND RECEIPT.

This section to be completed whatever the nature of your claim.

Please provide a full description of the events leading to your claim

Continue on another sheet if neccesary

Have you ever made any other insurance claims (except motor vehicle)? Yes ☐ No ☐

If Yes, please give date, name of company, type and amount of claim

Have you any other insurance which may cover this claim? Yes ☐ No ☐

If Yes, with whom?

YOU SHOULD NOW PROCEED TO WHICHEVER SECTION(S) OF THE CLAIM FORM IS APPROPRIATE TO YOUR CLAIM.

THE DECLARATION ON THE FINAL PAGE MUST BE SIGNED AND DATED.

BAGGAGE CLAIM

For all claims in respect of baggage lost, damaged or delayed by a carrier, we will require a full copy of the claim you have submitted to them along with their response and settlement breakdown.

Date of incident / / Time am pm

Date discovered / / Time am pm

Place where loss, theft or damage occurred

To whom was the incident reported? Police Carrier Other Date / / Time

You must attach the original reports given to you. If you do not have a report please advise why.

DETAILS OF LOSS OF BAGGAGE

Proof of value and ownership in the form of purchase receipts, valuation certificates obtained prior to the loss, guarantee cards and instruction booklets MUST be included.

Description of property lost, destroyed or damaged	Date of purchase	Original price paid	From whom purchased	Office use only
	/ /			
	/ /			
	/ /			
	/ /			
	/ /			
	/ /			
	/ /			
	/ /			
	/ /			
	/ /			

Continue on a separate sheet if necessary Total $

CANCELLATION CHARGES

You must provide documentation from the tour operator, carrier and travel agent verifying the cancellation charges imposed by them.

Name of person causing cancellation Date of birth / /

Relationship to person cancelling

Reason for cancelling (death, illness etc)

Date of incident / / Date holiday/journey cancelled / /

Names of all who are cancelling

Total cost of holiday (excluding insurance)

Total amount refunded by tour operator/carrier

Total amount of claim

The medical certificate on page 4 of this form must be completed in cases of cancellation arising from death, illness or injury. In the event of a death a copy of the death certificate will be required. You must include independent evidence to support your claim if from any other insured cause.

ADDITIONAL EXPENSES

Please attach receipts for all additional expenditure incurred.

Medical certificate: If additional expenses were incurred because of medical reasons the medical certificate on page 4 must be completed by the usual doctor (GP) of the person whose state of health/injury caused you to incur the additional expenses.

Relationship to you of the person whose state of health caused you to incur the additional expenses

List of expenditure for which reimbursement is required	Amount claimed

MEDICAL EXPENSES

Name of ill/injured person

Date of birth / /

Relationship to insured

Nature of illness/injury

Did you contact our 24-hour assistance service Yes ☐ No ☐ If Yes, date / /

Has the ill/injured person suffered from the same or similar illness/injury before? Yes ☐ No ☐

If Yes, please give details including dates

Was a doctor consulted at the time of booking the holiday? Yes ☐ No ☐

Did he/she consider the ill/injured person fit to travel? Yes ☐ No ☐

Name and address of ill/injured person's usual doctor

Name and address of doctor who treated illness/injury

If admitted to hospital

Date admitted / / Time am ☐ pm ☐

Date discharged / / Time am ☐ pm ☐

Date of expenses	Name of Dr, clinic or other authority who issued receipts/invoices	Cost incurred (state currency)	Paid by yourself
/ /			Yes ☐ No ☐
/ /			Yes ☐ No ☐
/ /			Yes ☐ No ☐
/ /			Yes ☐ No ☐
/ /			Yes ☐ No ☐

(Continue on a separate sheet if necessary)

Except in the case of minor illness or injury the medical certificate on page 4 will be required. We must ask you to note that where this is not completed we reserve the right to require its completion at a later date. In the event of death a copy of the death certificate will be required. If the claim is for repatriation or curtailment of your journey you should include the medical certificate issued by the treating doctor confirming the necessity of this.

MEDICAL CERTIFICATE

To be completed by the usual doctor (GP) of the person whose state of health/injury has caused you to make this claim.

Name of patient | Date of birth / /

Are you his/her usual GP? | For how long

Please provide precise diagnosis of the illness/injury

Date of onset of illness/injury / / | Date on which you were first consulted / / | Date referred to a specialist / /

Name and address of specialist/surgeon

Is the described condition caused, accelerated or traceable to any recurring illness or condition? Yes ☐ No ☐

If Yes, please confirm dates of consultations regarding the condition and prescriptions given over the past 6 months

Please give details of any chronic disease or illness or physical defect or infirmity from which he/she suffers

How long was or will the patient be prevented from travelling? From / / to / /

Had patient planned to travel against your prior advice?

Was the patient confined to bed, home or hospital for 3 days or more in the 30 days prior to the purchase of travel insurance? Yes ☐ No ☐

Details

Did the patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment? Yes ☐ No ☐

Name of Doctor | Signature

Address

Date / /

CLAIMANTS DECLARATION

Declaration
I do solemnly and sincerely declare that the particulars contained in this form are true and correct in every detail and I agree that if I have made, or in any further declaration in respect of the above said claim shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Furthermore
In consideration of QBE Insurance (International) Limited agreeing to meet payment of this claim I/we hereby agree to discharge QBE Insurance (International) Limited from any further liability, claims or demands in respect of this claim. Any property which is the subject of this claim will be owned by the Insurer by virtue of the claim having been settled in respect of such property.

Privacy Act
I acknowledge that QBE Insurance (International) Limited require this personal information from me before it will decide whether to accept this claim. This information will be retained and held by QBE Insurance (International) Limited. I understand that the Privacy Act entitles me to have access to and require correction of this information. I authorise QBE Insurance (International) Limited to disclose this information to its advisers, other insurers, to reinsurers and other parties. I further authorise QBE Insurance (International) Limited to obtain information about me held by any other party that is in its view relevant to this claim.

Medical authority
I hereby authorise any hospital, physician or other person who has attended me to furnish to QBE Insurance (International) Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and all copies of hospital or medical records. I agree that a photostat copy of this authorisation shall be considered as effective as the original.

Signature | Date / /