

TRAVEL INSURANCE CLAIM FORM

Effective 1 November 2007

Email: travelclaims@mondial-assistance.com.au

Phone: 1300 136 261

Facsimile: (07) 3305 7016

Postal Address:

Travel Claims Department
PO Box 162
Toowong QLD 4066
Australia

This travel insurance is arranged and managed by ETI Australia Pty Ltd, trading as Mondial Assistance (Mondial Assistance) ABN 52 097 227 177, AFSL 245631 and is underwritten by Allianz Australia Insurance Limited (Allianz) ABN 15 000 122 850, AFSL 234708. Mondial Assistance is authorised by Allianz to enter into and arrange the policy and deal with and settle any claims under it, as an agent of Allianz, not as your agent.

Claim No: _____

Date Received: _____

(Office Use Only)

PRIVACY The Privacy Act 1988 requires us to tell you that Mondial Assistance as agent for Allianz collect your personal information in order to handle your claim. We may have to disclose your personal information to third parties such as other insurers, travel agents, medical practitioners, intermediaries, loss adjusters, external claims data collectors, investigators and the Insurance Reference Services (IRS), or as required by law. You have the right to seek access to your personal information at any time. Please contact Mondial Assistance on 1300 725 154 for access.

INTERNAL DISPUTE RESOLUTION Disputes are not an everyday occurrence, however, Mondial Assistance provides an internal dispute resolution process should any dispute arise. Please feel free to ask for details. If you are not satisfied with the outcome of this process, we will advise you how to contact the insurance industry's external independent complaints scheme.

FRAUD Insurance fraud places additional costs on honest policyholders. Fraudulent claims force insurance premiums to rise. We encourage the community to assist in the prevention of insurance fraud. You can help by reporting insurance fraud. All information will be treated as confidential and protected to the full extent under law. Report insurance fraud by calling 1800 453 937.

STEP 1 – CLAIM FORM COMPLETION REQUIREMENTS

- Please read this claim form carefully and complete ALL steps outlined on this form.
- Please use block letters.
- Please retain a copy of ALL documents for your records.
- Documents in a foreign language are required to be translated into English at your own expense.
- The claim form and ALL supporting documentation may be mailed, emailed or faxed to us. **Please note: We reserve the right to request the original receipts, reports or any other documentation be submitted in order to substantiate the claim.**
- Please refer to the specified documentation requirements that you will need to provide when lodging your claim. As each claim is unique, further information may be requested by us.
- **A copy of your Certificate of Insurance must be supplied with your claim.**
- **If any part of your claim is of a dishonest or fraudulent nature, then your claim will be denied and will be referred to the appropriate authorities.**

STEP 2 – CLIENT DETAILS

A. Client Details

1. Travel Insurance Policy Number: _____

2. Surname of policy holder/s (as shown on the Certificate of Insurance): _____
Surname of policy holder/s: _____

3. Given Name/s: _____

4. Date of Birth: _____
Date of Birth: _____
Date of Birth: _____

5. Home Address: _____
Postcode: _____

6. Postal Address (if different to home address): _____
Postcode: _____

7. Telephone Numbers: Home: () Mobile: Work: ()

8. Email Address: _____

9. Occupation: _____

10. Travel Agency responsible for booking arrangements: _____

11. Address and phone number of Travel Agency: _____

12. Travel Consultant's Name: _____

13. Date of booking arrangements: _____

14. Date of Insurance payment: _____

15. Travel Destination: _____

16. Date of Departure: _____

17. Date of Return: _____

If you wish to give authority for another person to act on your behalf in respect to this claim you must complete the following details (otherwise we will not be able to give any information about your claim to any other person).

I/We, hereby authorise (Name): _____
of (Address): _____ Postcode: _____
Phone: _____ Mobile: _____

to act on our behalf in respect to this claim and to be provided with information relating to the claim.

B. Insurance Arrangements

1. Were the travel arrangements paid for by credit card?

Yes No

If Yes, please complete the following:

Credit Card Provider (e.g. Commonwealth Bank) _____

<input checked="" type="checkbox"/> Please tick correct box	Silver	Gold	Platinum	Other (please specify):
Visa				
Mastercard				
Diners				
Amex				
Other (please specify):				

2. Do you have a Travel Insurance Benefit Cover under your credit card?

Yes No

If Yes, have you made a claim against this?

Yes No

3. Do you have private health insurance?

Yes No

If Yes, please complete the following:

Name of Fund: _____

Membership Number: _____

Have you made a claim under this policy?

Yes No

(If Yes, include evidence of the amount received from the fund)

4. Do you have Personal Effects Cover included in your home contents insurance?

Yes No

If Yes, please complete the following:

Name of the Insurance Company: _____

Policy Number: _____

Have you lodged a claim for this loss under this policy?

Yes No

C. GST Purposes (Only applies if your policy was purchased for a business)

Note: If you are entitled to an Input Tax Credit (ITC) for the GST on your policy, you need to advise us of this entitlement to ensure GST/ITC is dealt with appropriately in separate settlement proceeds.

If you are a business and registered for GST and do not provide us with your ABN, we may have to withhold tax on payments we make under your claim.

1. The ITC on my premium is _____ %

2. My ABN is: _____

D. Previous Travel Claims History

1. Have you made previous travel insurance claims? Yes No If Yes, please answer questions 2 to 7. If No, please go to Step 3 (next page)

2. Date(s): _____

3. Name of Insurance Company claimed from: _____

4. Claim Number: _____

5. Amount claimed: _____

6. Amount paid: _____

7. Please provide full details of the event that led to the claim:

STEP 3 – CLAIM INFORMATION

In this Section we will ask you the circumstances of your claim and the amount that you are claiming.

Please tick the applicable box(s) relating to your claim and answer the corresponding Section.

- A.** Overseas Medical and Dental Expenses Claim – please go to page 3
- B.** Cancellation Claim (Cancellation of Pre-paid Arrangements) – please go to page 4
- C.** Additional Expenses Claim (Additional Travel or Accommodation Expenses) – please go to page 4
- D.** Luggage and Personal Effects Claim – please go to page 5
- E.** Rental Vehicle Excess Claim – please go to page 5
- F.** Delayed Luggage Allowance Claim – please go to page 6
- G.** Other – please go to page 6

Please answer all questions relating to what is being claimed, otherwise we will be unable to process your claim.

A. Overseas Medical and Dental Expenses Claim

1. Name of the person who incurred illness/injury: _____
2. The patient's relationship to the policy holder: _____
3. Nature of the illness/injury: _____

4. Did the illness/injury occur whilst the ill/injured person was working? Yes No
If Yes, please provide name, address and phone number of ill/injured person's employer: _____
5. How did the illness/injury occur? _____

6. Date first occurred: _____
7. Did you contact our 24 hour Assistance Service? Yes No If Yes, date: _____
8. Has the ill/injured person suffered from the same or similar illness/injury before? Yes No
If Yes, please provide details including dates: _____
9. Name, address and phone number of ill/injured person's usual Doctor/Dentist: _____

10. Name, address and phone number of Doctor/Dentist who treated the illness/injury whilst abroad: _____

11. Country where illness was treated: _____
12. If admitted to hospital: Date admitted: _____ Time: _____ am/pm
Date discharged: _____ Time: _____ am/pm

13. Please list each receipt/bill separately in the table below:

Name of Doctor/Dentist/ Pharmacy/Hospital or Provider	Treatment Performed	Date of Treatment	Amount Charged (State Currency)	Paid Yes / No	Refund from Health Funds
e.g. Doctor R Smith	e.g. Consultation	e.g. 10/02/07	e.g. EUR 100	e.g. Yes	e.g. EUR 75

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- The itemised account/s giving a breakdown and description of the costs claimed.
- The medical report/dental report/hospital records giving full details of the matter for which treatment was sought.

PLEASE PROVIDE US WITH A COMPLETED MEDICAL CERTIFICATE (SEE PAGE 7).

EXCEPT IN THE CASE OF A MINOR ILLNESS OR INJURY YOUR CLAIM CANNOT BE PROCESSED WITHOUT A COMPLETED MEDICAL CERTIFICATE.

B. Cancellation Claim

1. Date of travel cancellation/change: _____
2. Date of the incident that caused you to cancel your trip: _____
3. Was your travel cancelled/changed for a medical reason? Yes No If Yes, please answer questions from 4 to 8. If No, please answer questions 7 to 9.
4. Name of person who incurred the illness/injury: _____
5. Nature of the illness/injury: _____
6. Has the ill/injured person suffered from the same or similar illness/injury before? Yes No
7. Date your trip was originally booked: _____
8. Date your trip was cancelled: _____
9. Please provide details of the reason why you cancelled your trip:

10. Please list each receipt/bill separately in the table below:

Cost of Original Item Booked	Description of Booked Item	Name of Carrier/Travel Company	Date of Intended Use	Date of Cancellation	Amount of Refund Received	Taxes Charged on Cancelled Trip	Amount Being Claimed
e.g. AUD \$1500	e.g. London Flight QF1	e.g. Qantas	e.g. 10/02/07	e.g. 30/01/07	e.g. AUD \$500	e.g. AUD \$20	e.g. AUD \$1000

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- The travel agent's letter detailing all cancellation charges AND the Cancellation or Amendment Form at page 8 of this claim form, fully completed by your travel agent. This **MUST** show all amounts paid for your travel and amounts refunded.
- Any relevant documentation that which supports your reason for cancelling.
- If your travel was cancelled due to medical reasons, the Medical Certificate on page 7 **MUST** be completed by the Doctor/Dentist who recommended cancellation. Option 2 on the Medical Certificate needs to be completed.
- If your travel was cancelled due to the unfortunate event of a death, a copy of the Death Certificate will be required.

C. Additional Expenses Claim

1. Please state the reason/event that caused the additional expenses being incurred:

2. What was the unexpected cost incurred?

Please list each receipt/bill separately in the table below:

Date of Expense	Description of Cost	Cost	Date of Original Plan	Description of Original Cost	Cost
e.g. 24/07/07	e.g. Hotel in Paris	e.g. EUR 100	e.g. 24/07/07	e.g. Flight to Munich	e.g. EUR 75

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- The travel agent's letter detailing all cancellation charges AND the Cancellation or Amendment Form at page 8 of this claim form, fully completed by your travel agent. This **MUST** show all amounts paid for your travel and amounts refunded.
- A copy of your itinerary showing the details of your travel arrangements.
- The copy of all receipts, credit card vouchers or statements for any amounts you want us to pay for.
- If the Additional Costs were incurred because of a transport provider, please attach a letter from them confirming the reason why.
- If the Additional Costs were incurred due to an illness, Option 3 on the Medical Certificate on page 7 must be completed by the Doctor/Dentist of the person whose state of health or death caused this claim (be this the insured or any other party).
- If your travel was cancelled due to the unfortunate event of a death, a copy of the Death Certificate will be required.

D. Luggage and Personal Effects Claim

1. Date of Incident: _____ 2. Time: _____ am/pm
3. Location: _____ 4. Country: _____
5. Please state in full exactly what occurred (*please attach a letter if insufficient space*):
- _____
- _____
- _____

6. Did you report the event to the police? Yes No
 If Yes, when and where? Police Station: _____ Officer Name: _____ Report Reference: _____
 Did you report the event to any other authority? Yes No
7. Were the goods stolen from your vehicle? Yes No
 If Yes, were the goods under your control when they were stolen or damaged? Yes No
8. Have you claimed the loss under your household contents insurance? Yes No
9. Have you replaced any of the items which were stolen or damaged? Yes No
 If Yes, please provide proof of purchase.

10. Please complete the below schedule in full:

Full Description of Article	Original Purchase Price (State Currency)	Date of Original Purchase	Place of Purchase	Amount Claimed	Proof of Ownership attached? Yes / No
e.g. Silver 1998 Seiko Digital Watch	e.g. EUR 100	e.g. 24/07/06	e.g. Paris	e.g. EUR 75	e.g. Yes (receipt attached)

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

YOUR CLAIM WILL NOT BE PAID WITHOUT PROOF OF OWNERSHIP.

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- Proof of Ownership – This may be in the form of receipts, warranties, invoices, statements, guarantees, valuations, credit card statements, boxes or accessories.
- A Police Report (if the claim is theft related).
- In the case of damaged items – please send us a quotation for repairs and the damaged items.
- A loss report from the authority you reported the loss to: e.g. Police Report, Letter from Hotel, or a Property Irregularity Report (PIR) from the Carrier.
- If applicable, a letter from the carrier outlining their compensation paid to you.
- Your airline tickets and baggage tags.

E. Rental Vehicle Excess Claim

1. Date and time of incident: _____ 2. Location of incident: _____
3. Rental car company name: _____ 4. Country where the vehicle was rented: _____
5. Please state in full, exactly what happened for the claim to arise (if necessary, a diagram may be used to depict the event):
- _____
- _____
- _____

6. Was the damage due to a collision with another vehicle? Yes No
 If Yes, please provide the name and address of the person who was driving the other vehicle involved in the collision:
- _____

Please provide the registration number of the other vehicle:

7. Please provide the name and address of the other drivers' Insurance Company:
- _____

8. Did police attend the incident? Yes No

9. Was the accident your fault? Yes No

10. Repair costs: _____

11. Date the damage was paid for: _____

12. Excess you were liable to pay: _____

13. Amount you are claiming for: _____

14. Have you received compensation from any person or party involved in the accident or incident: Yes No

If Yes, please state the amount received:

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- A copy of the rental vehicle agreement.
- A copy of the repair invoice/quote.
- A copy of the receipt for payment of the excess.
- A copy of the police report if the vehicle was involved in an accident.
- A copy of the rental company incident report.

F. Delayed Luggage Expenses Claim

1. Name of carrier who delayed your luggage:

2. Arrival date:

3. Arrival time:

am/pm

4. Date that your luggage was returned to you:

Time of return:

am/pm

5. What compensation was received from the carrier?

6. Please complete the below schedule in full:

Description of Personal Effect Purchased	Date of Purchase	Price Paid	Store from where Item was purchased	Receipt attached Yes / No
e.g. Woollen Jumper	e.g. 10/02/05	e.g. EUR 100	e.g. Benetton of London	e.g. Yes (receipt attached)

Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- | | |
|---|---|
| <input type="checkbox"/> A copy of your Certificate of Insurance must be supplied with your claim. | <input type="checkbox"/> The receipts, credit card vouchers or statements showing the monetary amount of the essential item(s) purchased. |
| <input type="checkbox"/> A loss report issued by the carrier (usually in the form of a Property Irregularity Report (PIR)). | <input type="checkbox"/> Your airline tickets and baggage tags. |
| <input type="checkbox"/> Confirmation of the date and time the delayed luggage was delivered. | |
| <input type="checkbox"/> Letter from the carrier showing compensation. | |

G. Other

1. Please tell us in as much detail as possible what happened to you in order for you to make this claim. Be as specific as possible, including dates and amounts paid. If there is not enough room in the space provided, you may continue your description of the events on a separate piece of paper.

2. Which Policy Benefit Section(s) do you believe is the most applicable Section under which you can make this claim?

PLEASE PROVIDE US WITH ALL OF THE FOLLOWING REQUIRED DOCUMENTATION RELATING TO YOUR CLAIM:

- A copy of your Certificate of Insurance must be supplied with your claim.
- Please provide ALL relevant documentation relevant to the application of this claim.
- To process your claim more efficiently, please provide us with as much information as possible.

STEP 4 – PAYMENT DETAILS AND DECLARATION

1. For faster payment, provide your bank details for a direct credit to your nominated bank account. We cannot deposit into a credit card account.

Note that for an unpaid account the payment will be issued to the provider. In such event, we cannot make payment to the provider until we receive payment of any excess payable from you.

Name of Bank:

Branch:

Account Holder:

BSB Number: -

Account Number:

2. By cheque to your postal address:

Postcode:

CLAIM SUBMISSION CERTIFICATION

I/We certify that this claim form has been completed in full and all required information and documentation as specified on this claim form is attached to this signed claim form.

I/We certify that the information given in this form is truthful, accurate and complete. No information that is likely to affect this claim has been withheld.

I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We understand that if this claim is fraudulent, it will be reported to the relevant authorities.

I/We consent to the collection, use and disclosure of personal information in order to handle my/our claim.

I/We acknowledge that if I/we do not agree to the collection of this personal information then Mondial Assistance will be unable to process my/our claim.

I/We acknowledge that I/we will provide all necessary assistance as required by Mondial Assistance to process this claim.

NAME (PLEASE PRINT):

SIGNATURE:

DATE:

If you send this page separately, please complete the following: Claim Number:

Policy Number:

Claim No: _____

Policy No: _____

MEDICAL CERTIFICATE

To be completed by the claimant's usual Doctor/Dentist (at the claimant's expense) in all cases of cancellation and medical claims resulting from accident, illness or death.

Name of person to whom this certificate applies (i.e. the person whose state of health caused the claim): _____

Date of Birth: / /

Address: _____

Postcode: _____

Instructions to the Medical Professional:

Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Travel Insurance claim.

1. (a) Are you the patient's usual medical attendant? _____ If so, for how long? _____

(b) If not, do you have access to their medical records? _____

The claimant must indicate (by tick box) which is applicable, question 2 or 3.

2. **Alteration to/cancellation of travel arrangements prior to travel.**

(a) Did you recommend that travel be cancelled or postponed due to the patient's state of health? _____

What was the intended date of travel? _____

(b) Please give precise details of the nature of the illness or injury which gave rise to this recommendation (including the final diagnosis):

(c) On what date did you make this recommendation? / /

(d) On what date did the patient first become aware of their symptoms? / /

(e) On what date were you first made aware of the condition, or change in the condition? / /

(f) Has the patient previously been investigated, diagnosed or treated in respect of the same/similar/related illness or injury?

(g) If Yes, please provide details from the patient's history (e.g. dates of incidents, advice, treatment and/or medication):

(h) Did the patient make the travel arrangements against your advice (or the advice of another medical professional)?

OR

3. **Treatment costs/ additional expenses incurred during travel.**

(a) What do you understand to be the illness or injury which resulted in the need to seek medical care/ interrupt the patient's travel plans?

(b) Has the patient previously been investigated, diagnosed or treated in respect of the same/similar/related illness or injury?

(c) If Yes, please provide details from the patient's history (e.g. dates of incidents, advice, treatment and/or medication):

(d) Was there any indication that medical care may be required on the journey?

(e) Was the patient non-compliant with medical advice whilst on the journey?

(f) Did the patient travel against your advice (or the advice of another medical professional)?

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

Doctor's Signature: _____

Date: _____

Doctor's Stamp:

Please post this form together with your claim form and all supporting documentation to Travel Claims Department, PO Box 162, Toowong QLD 4066 Australia

TRAVEL CANCELLATION AND/OR AMENDMENT FORM

TO BE COMPLETED BY YOUR TRAVEL AGENT

CUSTOMERS: Please have this form completed in full by your Travel Agent when making a claim for Cancellation or Additional Expenses.

TRAVEL AGENTS: Please complete this form for any non-refundable, prepaid Cancellation claims or Additional Expenses claims.

This form MUST be completed in full to enable assessment of the claim.

Client's Full Name: _____

Client's Address: _____

Postcode: _____

Claim Number: _____ Client's Policy Number: _____

Provider name	Original journey details	Amount paid	Provider refund amount excluding taxes		Refundable taxes*	Total refunds	Non-refundable taxes*	Provider cancellation fees	Agent cancellation fees	TOTAL claiming through insurance
			Refund	Credit						
		A	B	C	D	E	F	G	H	I
						= B + C + D		= A - E		= F + G + H
e.g. Qantas	e.g. Flight to London Heathrow	e.g. AUD \$1,000	e.g. AUD \$500	e.g. AUD \$50	e.g. AUD \$100	e.g. 500 + 50 + 100 = AUD \$650	e.g. AUD \$50	e.g. 1,000 - 650 = AUD \$350	e.g. AUD \$100	e.g. 50 + 350 + 100 = AUD \$500

*Unused taxes (to be claimed through provider)

IMPORTANT – DOCUMENTATION REQUIRED:

1. Please provide ALL Terms and Conditions for all components of the travels showing the published cancellation conditions.
2. If a ticket or any bookings are non-refundable, the tickets or vouchers must be sent to Mondial Assistance with the claim documentation.
3. Please attach a copy of the itemised invoice for all components of the travels which was given to the client on official letterhead.
4. A copy of their intended itinerary MUST also be sent to Mondial Assistance.

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

Travel Agency Name: _____

Travel Agency Address: _____

Phone: _____ Fax: _____ Email: _____

Travel Consultant's Name: _____

SIGNATURE: _____ **DATE:** _____

Please post this form together with your claim form and all supporting documentation to Travel Claims Department, PO Box 162, Toowong QLD 4066 Australia or fax it to (07) 3305 7016 or email it to travelclaims@mondial-assistance.com.au

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