



Travel Claim

The issue of this form does not constitute an admission of liability on the part of the insurer.

Policy Number

Claim Number

IMPORTANT INFORMATION

1. Please complete the Policy Details Section and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully.
3. We may ask for details of your medical history, or of the person whose accident, illness or death necessitated additional expenditure or the cancellation of the journey. Such information must be obtained at your expense.
4. To avoid delay in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
5. Claims may be subject to an excess as described in your Policy.

Policy Details Section										
Certificate Number										Please attach your certificate
Full Name (Block Letters)	Surname				Given Name(s)					
Postal Address							State		Postcode	
Are you registered for GST?	No <input type="checkbox"/>	Yes <input type="checkbox"/>	What is your ABN?							
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to the Policy?	No <input type="checkbox"/>			Yes <input type="checkbox"/> – Will you be claiming an amount less than 100%?						
	No <input type="checkbox"/>			Yes <input type="checkbox"/> – Specify amount claimed			%			
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	No <input type="checkbox"/>			Yes <input type="checkbox"/> – Will you be claiming an amount less than 100%?						
	No <input type="checkbox"/>			Yes <input type="checkbox"/> – Specify amount claimed			%			
Occupation						Date of Birth	/	/		
Contact Numbers	Business	()				Private	()			
	Facsimile	()				Mobile				
Travel Agent						Telephone	()			
Date of Booking Travel Arrangements	/	/		Date of Departure	/	/		Date of Return	/	/
Have you made previous claims for travel insurance?	No <input type="checkbox"/>			Yes <input type="checkbox"/> – If "Yes", please give details						
Name of Insurer								Date of Claim		
								/ /		
								/ /		

Section 1. Cancellation Claims									
The following documents are required in support of your claim Please tick (✓) when attached									
Doctor's Certificate (see section 4)	<input type="checkbox"/>	Travel Agent's letter confirming details of tour costings and cancellation charges	<input type="checkbox"/>						
Transport provider's reports	<input type="checkbox"/>								
Reasons for Cancellation									
Date of Cancellation	/	/							
Where cancellation was due to accident, illness or death, please state the name of the person whose accident, illness or death necessitated the cancellation:									
Name						Relationship to Insured			
Amount claimed for irrecoverable prepaid travel costs	\$								
PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM									

Section 2. Luggage and Personal Effects

The following documents are required in support of your claim Please tick (✓) when attached

Police or responsible authority's report Original purchase receipts/proof of ownership
 Quotation for repair of damage Transport provider's reports

Date of loss / / Time am/pm

Location Country

Please state exactly what happened.

If space is insufficient, please attach details and a sketch if necessary.

What action did you take to recover the lost articles?

If space is insufficient, please attach details.

Which responsible authority (e.g. Police) was notified?

Date notified / / Location Time am/pm

Are your home contents insured? No Yes – give details

Name of Insurer Policy No.

Are you a member of private health fund? No Yes – give details

Name of Fund

Please note: If you are entitled to recover losses from any other insurance policy, or other source, please do so and give details of amounts recovered.

If space is insufficient, please attach details.

Full description of article(s) and details of loss or damage where applicable	Place of purchase	Date of purchase	Original purchase price	Amount claimed

If space is insufficient, please attach details.

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM

Section 3. Medical Emergency and Additional Expenses Claims

The following documents/statements are required in support of your claim Please tick (✓) when attached

Original medical/hospital accounts	<input type="checkbox"/>	Accounts in support of accommodation expenses	<input type="checkbox"/>
Medical certificate supporting need for altered travel plans	<input type="checkbox"/>	Copy of Travel Itinerary	<input type="checkbox"/>

Date of accident, illness or circumstances	/ /	Time	am/pm	Country
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Particulars of claim.

If your claim arises from injury or illness, please specify the nature of such injury or illness.

Name of person whose injury or illness caused additional expenditure

Their relationship to you

Has the illness or injury occurred before? No Yes – If “Yes”, please supply the following details

Usual Doctor’s Name

Doctor’s Telephone no. () Date of Last Visit / /

If additional expenses have been incurred as the result of an accident, illness or death of a person in Australia, please state:

Their relationship to you

Expenditure for which reimbursement is claimed		Amount claimed
1. Provider (eg. Dr. J. Smith, Bali Hospital etc.)	Service (i.e. Medical, Hospital etc.)	
2. Additional expenses		
3. Cancellation/Loss deposits (Please attach documents from your travel agent showing cancellation charges)		

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM

Medical Authority

With regards to medical, cancellation and/or additional expenses –
I hereby authorise any hospital, physician or other person who has attended or examined me to furnish to QBE Insurance (Australia) Limited or their representative any and all information in respect of treatment given for:

A photostat copy of the this authorisation shall be considered as effective and valid as the original.

Name of Usual Doctor				
Address of Usual Doctor			State	Postcode

Privacy

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our website www.qbe.com or contact the Compliance Manager on 02 9375 4656 or email compliance.manager@qbe.com for further information.

Declaration and Authorisation

The information and answers given above are true, correct and complete in every detail.

1. I/We understand the claim may be refused if information is not true or is withheld.
2. I/We authorise QBE Insurance (Australia) Limited to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Medical Authority: I authorise any hospital, physician or other person who attended me, to give QBE Insurance (Australia) Limited or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

A photocopy of this authorisation will be considered as effective and valid as the original.

Signature of Insured 1. _____ Date / /

Signature of Insured 2. _____ Date / /

Section 4. Medical Certificate - Completion by Doctor

To be obtained at the claimant's expense from the patient's usual medical practitioner in Australia (or specialist where applicable) in all cases of medical claims and cancellation or additional expenses claims resulting from accident, illness or death.

Name of person to whom this certificate applies (i.e. the person whose accident, illness or death necessitates the completion of this certificate)

	Age	
Are you his/her usual medical attendant?	No <input type="checkbox"/> Yes <input type="checkbox"/> – If "Yes", for how long?	
Please give precise details of the nature of the illness or injury		
Please state the date of the onset of the illness, or the date on which the injuries were sustained		/ /
Please state the date you were first consulted for this condition		/ /
Have you previously treated this patient for the same/similar/related condition as described above?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
If "Yes", please state when		
To the best of your knowledge has any other doctor previously treated this patient for the same/similar/related condition?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
If "Yes", please state the last time, and what treatment and/or medication was prescribed.		
Was the patient advised to continue this treatment and/or medication whilst away?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
Are you prepared to certify that solely due to the condition described above, the claimant(s) is/are compelled to cancel the holiday arrangements?	No <input type="checkbox"/> Yes <input type="checkbox"/>	
I certify that the foregoing statements are correct		
Doctor's Name		
Doctor's Address		
	State	Postcode
Doctor's Qualification		
Doctor's Signature	<input checked="" type="checkbox"/>	Date / /

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM.

Return the completed form to your Financial Services Provider or mail to QBE Insurance, GPO Box 4229, Sydney NSW 2001.

This Policy is underwritten by QBE Insurance (Australia) Limited ABN 78 003 191 035 of 82 Pitt Street, Sydney.