making relationships count

CLAIM FORM: TRAVEL INSURANCE

THE ISSUE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

SECTION 1: CLAIMANT DETAILS

Name of Insured / Employer: _____

Policy Number: _____

Claimant Given Name and Family Name: _____

Occupation: _____ Date of Birth: _____ /_____ / _____

Address: _____ Postcode: _____

Telephone No. (Home): _____ Business: _____

Email address: _____

SECTION 2: TRAVEL INFORMATION

Date of Departure: _____ /_____ / _____ Date of Return / Expected Return: _____ /_____ / _____

Reason for Travel: _____

Departure Country: _____ Departure City: _____

Destination Country: _____ Destination City: _____

SECTION 3: CORPORATE TRAVEL AUTHORISATION

Name: _____ Position: _____

Company Name: _____

I hereby confirm that _____ (*Claimant Name*) is an insured person and was on an approved business journey on the Date of Loss.

Signature: _____ Date: _____ /_____ / _____

SECTION 4: PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account. Please complete the following:

Bank: _____

SWIFT CODE (FOR NON AUSTRALIAN BANK): _____

Account Name(s): _____

BSB Number: _____ Accout Number: _____

GST Information (For Australian Claims Only)

(a) Are you registered for GST Purposes? Yes ☐ No ☐

(b) What is your Australian Business Number (ABN)? _____

This form must be fully completed in the sections applicable to your claim and signed.

SECTION 5: LUGGAGE and PERSONAL EFFECTS and MONEY

Give full details of how loss damage or theft occurred: (Detail each event)

_____

_____

_____

_____

_____

Date of occurrence: _____ /_____ / _____ Time: _____ am/pm

Date loss reported: _____ /_____ / _____ Time: _____ am/pm

Loss reported to – Name: _____

Address: _____

Were articles lost by Carrier? (eg Airline) Yes ☐ No ☐ Name: _____

Have you lodged a claim or complaint against any Carrier/Airline or other authority or against any individual responsible for the loss or damage to your property? If so, please give details and attach copies of correspondence.

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

Airline	Claim No.

SECTION 5: LUGGAGE and PERSONAL EFFECTS and MONEY cont.

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 YES – who is the owner? _____

Description and size of suitcase in which missing goods carried: _____

_____

Full details of articles claimed (include value of cases)	Name and address from whom goods were purchased	Date of purchase	Purchase price	Amount claimed	Remarks

SECTION 6: MONEY

Date notified: _____ /_____ / _____ To whom: _____

Which police were advised? State Police Station and **attach a copy of the report** if available.

Description of the incident: _____

_____

Details of claim:

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 purchase of lost goods (e.g. Receipts, Guarantee or Valuation Certificates, Card Vouchers, etc.)

***Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason.**

_____

_____

_____

SECTION 7: MEDICAL EXPENSES, MEDICAL EVACUATION AND ADDITIONAL EXPENSES

Type of injury or sickness: _____

Date of accident or commencement of sickness: _____

Injury – give full details of accident: _____

_____

Date of first medical consultation: _____ /_____ / _____ Name of doctor or hospital: _____

Details of other treatment by Doctors/Hospital _____

Dates in 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 etc.: _____

_____

Are you a member of a Private Health Insurance Fund e.g. Medibank? Yes ☐ No ☐

Name of Fund: _____

N.B. If you are a member of a Private Health Fund you must claim from that fund before submitting this claim. THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Original Doctor's / Hospital accounts and receipts together with statements from Medicare and Private Health funds.

2. Original Doctor's Certificate.

***Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the items please advise the reason:**

_____

_____

SECTION 8: CANCELLATION, CURTAILMENT AND LOSS OF DEPOSITS

What was the reason you could not commence your proposed journey or complete the return flight:

_____

_____

_____

_____

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, please provide details

Name: _____

Address: _____

Relationship: _____ Age: _____

Nature of complaint preventing travel: _____

Date of first Medical Treatment: _____

Has the Injured / sick person had a similar condition in the past? Yes ☐ No ☐

Name and address of patient's normal Doctor: _____

Date you advised Travel Agent to cancel bookings: _____ /_____ / _____

Amount of Deposit paid $ _____ Date paid: _____ /_____ / _____

Balance of Full Fare paid: $ _____ Date paid: _____ /_____ / _____

TOTAL PAID: $ _____

Refund received on cancellation: $ _____ (excluding Insurance Premium)

Were any alternative arrangements offered or made? (Give details)

Were any additional fares incurred as a result of cancellation: (Give details)

SECTION 8: CANCELLATION, CURTAILMENT AND LOSS OF DEPOSITS

(Complete this section for additional expenses)

Reason for incurring additional expenses or forfeiting travel or Accommodation expenses:

Date of Expense	Details of Expenses	Amount Claimed (please state currency)

Were these expenses incurred as a result of Injury or Sickness as claimed on previous page? Yes ☐ No ☐

If these expenses were incurred as a result of Injury or Sickness to any other person, please give details of cause, name, address and age of person.

Cause:

Name & Details:

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Original receipts and/or Tickets relating to additional expenses incurred
2. Proof of cause i.e. Original Doctor's/Hospital's Certificate relating to Injured or Sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport.

*** Failure to provide these items may result in delays in processing your claim.**

If it is impossible to provide any of the items please advise the reason:

SECTION 9: ACCIDENTAL DEATH CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The Original Policy Document.
2. Original of the Death Certificate which will be returned to you.
3. Copy of Coroner's Depositions and Findings (if applicable)
4. Original Birth Certificate which will be returned to you.

***Failure to provide these items may result in delays in processing your claim.**

What was the cause of death?

When did the accident occur? Date: _____ /_____ / _____ Time: _____am/pm

Was a coronial inquest held or is one to be held? Yes ☐ No ☐

If YES, give details

Name and Address of usual family doctor:

_____

_____

How long has the doctor been known to the patient? _____

SECTION 10: HIRE CAR EXCESS CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The Hire Car Agreement.
2. Notice from the Hire Car Company in respect of the excess or deductible.
3. Documentation evidencing payment of excess or deductible.
4. A copy of the Hire Car Repair Invoice from the Hire Company.

*** Failure to provide these items may result in delays in processing your claim.**

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

Date of Incident	Rental Vehicle Excess (Currency)	Actual Repair Costs (currency)	Amount Claimed

Should your claim not fall under any of the above, please contact Corporate Services Network Pty Ltd (CSN) for further details and to discuss coverage.

SECTION 11: CLAIM LODGEMENT DETAILS

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT

PROCESSES **(Please keep a copy of all documents sent to FHCS)**

Postal Address:	
Fullerton Health Corporate Services Level 10, 33 York St Sydney, NSW 2000	
Email Address: claims@fullertonhealthcs.com.au	**Fax No:** +61 2 8256 1775

Phone Number:

Once the claim form has been completed, sent, and received by FHCS, claim inquiries can be made to FHCS on: +61 (2) 8256 1770

Policy and coverage queries should first be directed to your Insurance Broker.

PRIVACY STATEMENT:

At DUAL Australia Pty Ltd, we are committed to compliance with the Privacy Act 1988 (Cth). We use the personal information you provide in connection with a claim to assess, administer and manage the claim. If you don't provide us with full information, we may not be able to do this. When assessing a claim, we may need to collect information from people like your insurance broker, employer, medical and financial advisers and Government agencies. If you provide us with information about someone else you must obtain their consent to do so.

We provide your information to the insurer we represent when we assess and administer your claim. When providing insurance terms or assessing your claim, we will tell you if the insurer is overseas and if so, where they are. We are part of the Hyperion Insurance Group and may provide your information to UK based Group entities who provide us with business support services. We may also provide your information to third parties such as: (1) your insurance broker or other person who acts for you; (2) contracted third party providers who supply us with services such as claims investigation and management companies, legal and medical advisers and loss adjusters; and (3) Government agencies (where we are required to do so by law). We will take all reasonable steps to ensure that our service providers comply with the Privacy Act.

Our Privacy Policy contains information about how you can access the information we hold about you, ask us to correct it, or make a privacy related complaint. You can obtain a copy from our Privacy Officer by telephone (+61 (0)2 9248 6300), email (reception@dualaustralia.com.au) or by visiting our website (www.dualaustralia.com.au).

By signing this claim form, you consent to the collection and use of your personal information as outlined above and in our Privacy Policy.

DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS:

I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim. I authorise any hospital, physician or other person who has attended me to furnish the claims manager Fullerton Health Corporate Services (FHCS) or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Your Signature: _____ Date: _____ /_____ / _____

Please Print Your Name: _____