ace insurance

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Travel Insurance Report Form

IMPORTANT INFORMATION

Please ensure this Form is completed in all Parts applicable to your claim. The Privacy Consent must be completed for all claims. Supporting documentation required is detailed below each Part.

The issue and acceptance of this Form does not constitute an admission of liability by the Company or a waiver of its rights.

Policy and Claimant Details

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Name of Policyholder/Insured

Name of Claimant (Mr/Mrs/Miss/Ms)

Policy Number / Credit Card Number (if applicable)

Address

Telephone — Home ( ) Business ( ) Mobile

Email Address

Date of Birth / / Occupation

Travel Agent — Date of Booking Travel Arrangements / /

Date of Departure / / **Date of Return** / /

Electronic Funds Transfer Details

Following ACE approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

Name of Financial Institution

Account Holder's Name:

BSB Number:

Account Number:

GST Information (For Australian Claims Only)

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

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

(c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? Yes ☐ No ☐

(d) IF **YES**, what percentage of the GST did you claim or are you entitled to claim? %
(if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

CANCELLATION CHARGES, LOSS OF DEPOSIT CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The Original Tickets/Vouchers if a refund is not obtainable.
2. Doctor's/Hospital Certificate specifying exact nature of condition suffered by Injured/Sick person.
3. Letter from Travel Agent verifying total cost of journey, value of unused portion of journey, cancellation charges incurred and total amount of refund received.

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

What was the reason you could not commence or complete your proposed journey?

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 so - 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 and date paid	$	Date	
Balance of full fare and date paid	$	Date	
Value of forfeited portion of journey (if applicable)	$		
Refund received on cancellation	$		
Full amount being claimed	$		

Were any alternative arrangements offered? If so, give details

Did you accept any of the alternative arrangements? Yes ☐ No ☐

What additional fares did you incur as a result of alterations to the arrangement?

OVERSEAS MEDICAL, DENTAL AND/OR HOSPITALISATION BENEFIT CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Original Doctor's/Hospital accounts and receipts together with details relating to medical benefit refunds.
2. Original Doctor's Certificate verifying nature of complaint suffered by you.

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

Type of Injury or Sickness	Date of Accident or commencement of Sickness

If 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 — Discharged / / am

List the Country and the currency of the Country in which you incurred the medical costs

Country:	Currency:	Total Amount:
Country:	Currency:	Total Amount:

Have you ever suffered from the same or similar complaint in the past? Yes ☐ No ☐

If Yes, give details, dates names and addresses of treating physicians

Name and Address of usual family doctor

How long has the doctor been known to the patient?

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

If Yes, please supply name of fund

PLEASE NOTE: All medical accounts must first be lodged with your Private Health Fund, if applicable.

The policy is only able to consider Non-Medicare claimable expenses.

EMERGENCY EXPENSES CLAIM
(For additional travel and accommodation incurred during the journey)

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Receipts and/or Tickets relating to additional expenses incurred.
2. Doctor's/Hospital Certificate specifying exact nature of condition suffered by Injured/Sick person.
3. Letter from Travel Agent or carrier verifying reason for additional expenses and/or any refund applicable.

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

Date/s Expenses Incurred	/ /	/ /

Reason for incurring additional travel or accommodation expenses

List the Country and the Currency of the Country in which you incurred the costs	Country: Currency:

List specifically the additional TRAVEL expenses	Details	Amount
		A$
		A$
		A$
		A$
	TOTAL	A$

List specifically the additional ACCOMMODATION expenses	Details	Amount
		A$
		A$
		A$
		A$
	TOTAL	A$

Were these expenses incurred as a result of Injury or Sickness as claimed in Part 1? 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, age of person and relationship to you		
	Name	Age
	Address	Relationship

Cause	

LUGGAGE, PERSONAL EFFECTS CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Report or letter from Authority (e.g. Police, Airline) regarding the loss.
2. Receipts Guarantee Certificates, Instruction Manuals, Valuation Certificates, Bankcard or Credit Card Vouchers or other proof of purchase for items claims.
3. Bank Statements, transaction receipts or other proof of cash claimed.
4. Quotations for replacement of items claimed.

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

Give full details of how losses, damage or thefts occurred: (Detail each event)

Date loss/damage occurred / /	Time am	Date loss/damage reported / /	Time am

Loss/damage reported to (Police, Airline or other authority) Name

Were articles lost/damaged by a Carrier? (e.g. Airline) Yes ☐ No ☐ Name

Have you yet 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, give details and attach copies of correspondence.
If not, you should proceed to claim with your Carrier/Airline before submitting your claim to ACE

Airline:	Claim No.

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

What Action was taken to recover lost items?

Are any of the items covered by other insurance? Yes ☐ No ☐

If **Yes** - Which company Policy Number

Were all the missing articles your property? Yes ☐ No ☐

If not, give details

Other comments (if necessary)

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	Original Date of Purchase	Original Purchase Price	Replacement Amount Claimed Aust. $	Remarks

ACCIDENTAL DEATH CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The original Policy Document.
2. Certified copy of Death Certificate.
3. Copy of Coroner's Depositions and Findings (if applicable).
4. Certified copy of Birth Certificate.

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

What was the cause of death?

When did the accident occur? Time am

Was a coronial inquest held or is one to be held? If so give details Yes ☐ No ☐

Name and Address of usual family doctor:

How long has the doctor been known to the patient?

PERSONAL LIABILITY CLAIM

THE FOLLOWING ITEM MUST BE INCLUDED WITH THIS CLAIM*

1. Letters or Demands of a claim made against you.
2. Quotations or receipts in support of a claim made against you.

***Failure to provide this item may result in delays in processing your claim.**

Bodily Injury - Provide relevant details - name, address, phone number and email address of Injured Party and details of Injury

Damage to Property - List all Property Damage together with name, address, phone number and email address of Party claiming damage against you

Is the Injury or Damage related to a travelling companion? Yes ☐ No ☐

Do you consider you were at fault? (If so, why)

RENTAL VEHICLE COLLISION AND THEFT EXCESS COVER CLAIM

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

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

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

Date Of Loss / /

Value of Excess/LDW $

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

ACE Insurance Limited Claim Privacy Consent, Medical Authority and Declaration

Claim Privacy Consent

ACE Insurance Limited (ACE) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principles.

A copy of our Privacy Policy is available on our website at www.aceinsurance.com.au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by ACE, or any third party that ACE provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:
- Any information provided in relation to your claim;
- Any information that is health information or sensitive information, including without limitation your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
- Any other personal information that you may provide to ACE or its third party contractors;
- Any information relating to any insurance policy on your life, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- Any information relating to your income, assets, liabilities and solvency; and
- Any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ACE group, other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. ACE may also disclose your personal information to witnesses in respect to your claim.

If you have a complaint or want more information about how ACE is managing your personal information, please contact the Privacy Officer, ACE Insurance Limited, GPO Box 4907, Sydney NSW 2001, Tel: +61 2 9335 3200 or email Privacy.AU@acegroup.com

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, ACE may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1800 815 675 or email CustomerService.AUNZ@acegroup.com.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to ACE using and disclosing my personal information pursuant to ACE's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to ACE's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to ACE such personal information (including health information) as ACE is its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to ACE in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint ACE to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant

Date / /

Name of Claimant

Signature of Witness

Date / /

Name of Witness

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To Be Completed by the Insured for all Claims on Corporate Travel Policies

I, (Company Representative) _____

confirm that (Insured Person) _____

is an employee/member of _____

and that he/she was on Authorised Business Travel on the Date of Loss.

Signature _____

Name _____

Title _____

Contact Number _____

Claim Reference (if known) _____

Policy Number (if known) _____