

TRAVEL INSURANCE CLAIM FORM

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.

Phone: 1800 775 520

Fax: (07) 3305 7016

Email: travelclaims@mondial-assistance.com.au

Postal Address:

CHI Claims
PO Box 162
Toowoong QLD 4066

Privacy

The Privacy Act 1988 requires us to tell you that Mondial Assistance as agent for Allianz collect your personal and sensitive information in order to calculate your loss and entitlements, determine liability, compile data and handle claims. When handling claims, we may have to disclose your personal and other information to third parties such as other insurers, travel agents, travel insurance providers, intermediaries, loss adjusters, external claims data collectors, investigators, the Insurance Reference Services (IRS), or other parties required by law. You have the right to seek access to your personal information and to correct it at any time. Please contact Mondial Assistance on 1800 755 520 and advise us of any changes.

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.

CLAIM COMPLETION GUIDELINES

- Please use block letters
- Please retain a copy of all documents for your records
- **Please attach original receipts, accounts and other documents**
- Section 1 must be completed for **all claims**

- Section 2 must be completed for Medical, Additional Expenses and/or Cancellation claims
- Section 3 must be completed for Luggage and Personal Effects claims
- Section 4 must be completed for **all claims**
- Section 5 must be completed by your usual doctor/dentist (as applicable) for Cancellation & Medical claims resulting from accident, illness or death.

SECTION 1 - CLIENT DETAILS

Claim No.
(Official Use Only)

Certificate / Policy No.

A copy of the Certificate of Insurance MUST be attached. If you do not have a copy please obtain one from the issuing agent before submitting your claim.

Mr Mrs Ms Miss Other

Surname of policyholder/s: Given Name/s: Date of Birth: / /

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Address of claimant / policy holder:
..... Postcode:

Occupation: Telephone: H () W ()
Email:

Name of travel agency: Telephone:

Address: Consultant:

Date travel arrangements booked: / / Date of departure: / / Date of return: / /

Have you made previous claims with respect to travel insurance? YES NO

If yes, give details:

Are you able to claim through any other source? YES NO If yes, have you made a claim? YES NO

If yes, give details and include evidence of the amount received:

SECTION 2 - MEDICAL, ADDITIONAL EXPENSES AND/OR CANCELLATION CLAIMS

Date of incident: / / Time: am/pm Country:

Cause of claim (include details of illness/injury):
.....
.....

1. If your claim results from **your** state of health **or** another person's state of health:

a) i) Name of person: Date of birth: / /

ii) Relationship of person to policyholder:

iii) Has the illness/injury occurred before? YES NO

If yes, give details:

iv) If an injury, how was the injury caused?

b) If you are claiming because you cancelled or postponed your trip prior to departure, you should have the Medical Certificate on Page 4 completed by the usual doctor of the person whose state of health caused your claim.

SECTION 3 - LUGGAGE AND PERSONAL EFFECTS CLAIMS

Date of incident: / / Time:am/pm

Location: Country

Please state in full exactly what happened: (attach letter if insufficient space)
.....
.....

Detail action taken to recover lost articles:

Were the police or a responsible authority notified? YES NO If yes, state who:

Location: Date : / / Time:am/pm

Do you have household contents insurance? YES NO

If yes, give name of insurance company:

Does it cover this incident? YES NO If yes, include evidence of the amount received from the other insurance company

If you are claiming for spectacles or dentures, are the items claimable through your private health fund? YES NO

If yes, include evidence of any amount received from the private health fund

Full Description of Articles Loss, Damaged or Essential Items Purchased (include details of damage where applicable)	Original Price (state currency)	Date and Place of Purchase (advise when received if a gift)	Amount Claimed (state currency)
.....
.....
.....
.....
.....
.....
.....
.....
.....

If insufficient space, attach further detail

IMPORTANT: DOCUMENTS REQUIRED TO PROCESS YOUR CLAIM

Attached (✓)

- a) Original police or responsible authority's report
- b) Any original purchase receipts and/or other proof of ownership (eg. warranty cards, instruction manuals) for the lost, stolen or damaged article/s
- c) Original quotation for repair of damage
- d) Original receipts for essential items purchased

SECTION 4 - PAYMENT DETAILS AND DECLARATION

Please indicate your preferred method of payment. We cannot deposit into a credit card account.

Note that for an unpaid account the cheque will be issued to the provider

For faster payment, direct Credit to your Name of Bank:

BSB Number: Account Number:

By cheque to your postal address

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 acknowledge that I/we have read and understood the Privacy Act 1988 information referred to above and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons affected by this claim and have the consent of all parties about whom information is collected. I/We acknowledge that if I/we do not agree to the collection of this personal and sensitive information then Mondial Assistance will be unable to process my/our claim.

SIGNATURE: Date : / /

If you want to give authority for another person to act on your behalf in respect to this claim complete the following details.

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.

SIGNATURE: Date : / /

SECTION 5 - MEDICAL CERTIFICATE

For completion by the patient's usual doctor / dentist (as applicable)

To be obtained **at the claimant's expense** from the patient's usual doctor in all cases of cancellation and medical claims resulting from accident, illness or death.

IMPORTANT The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries.

"PLEASE USE BLOCK LETTERS"

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

2. Are you the patient's usual medical attendant? If yes , for how long?
.....

3. Please give precise details of the nature of the illness or injury which gave rise to this claim:
.....
.....
.....

4. What was the date of onset of the illness or the date the injuries were received? /..... /.....

5. What was the date you first investigated or were consulted by the patient for this condition? /..... /.....

6. What was the date of diagnosis of the condition? /..... /.....

7. Has the patient previously been investigated, diagnosed or treated in respect of the same/similar/related illness or injury as described in question 3?
.....
.....
.....

If yes, when was the last time, prior to the occurrence which gave rise to this claim, and what treatment and/or medication was prescribed?
.....
.....

Was the patient advised to continue this treatment and/or medication whilst on the journey?
.....

8. Are you prepared to certify that solely due to the condition described in Question 3, the claimant/s was/were compelled to cancel the travel arrangements?
.....

9. Did you recommend that all travel be cancelled because of their illness/injury described in Question 3?
.....

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

Doctor's signature: Date:

Name: Qualification:

Address: Postcode:.....

Telephone: () Facsimile: ()