QBE Commercial

QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

Travel Claim

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

Policy No.		Claim No.	

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
Name	Surname	Given Name(s)	
Address			
		State	Postcode
Are you registered for GST? No ☐ Yes ☐	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 ☐ Yes ☐ – Will you be claiming an amount less than 100%?		
	No ☐ Yes ☐ – Specify amount claimed	%	
Are you entitled to claim on input tax credit for repairs or replacement of the item that has been lost or damaged?	No ☐ Yes ☐ – Will you be claiming an amount less than 100%?		
	No ☐ Yes ☐ – 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 ☐ Yes ☐ 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

Doctors's Certificate (see section 4) ☐ Travel Agent's letter confirming details of tour costings and cancellation charges ☐

Transport provider's reports ☐

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 ☐
Quotation for repair of damage ☐
Original purchase receipts/proof of ownership ☐
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?

Location

Date notified / / Time am/pm

Are your home contents insured? No ☐ Yes ☐ – give details

Name of Insurer Policy No.

Are your 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 ☐ Accounts in support of accommodation expenses ☐

Medical certificate supporting need for altered travel plans ☐ Copy of Travel Itinerary ☐

Date of accident, illness or circumstances / / Time am/pm

Country

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? Yes ☐ No ☐

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 (e.g. 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 this authorisation shall be considered as effective and valid as the original.

Name of Usual Doctor

Address of Usual Doctor

State Postcode

PRIVACY

The QBE Privacy Promise Brochure explains what sort of personal information we collect and hold about you and what we do with that information. Please contact your Financial Services Provider to obtain a copy of the QBE Privacy Promise Brochure. A copy of the brochure may also be obtained from any QBE Commercial office or from our website at www.qbecommercial.com

DECLARATION AND AUTHORISATION

The information and answers given in this claim form are true in every detail. No information has been withheld. I understand that the claim may be refused if information is withheld or false, misleading, untrue or concealed. I 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.

Signature of Insured X

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? Yes ☐ No ☐

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? Yes ☐ No ☐

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? Yes ☐ No ☐

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? Yes ☐ No ☐

Are you prepared to certify that solely due to the condition described above, the claimant(s) is/are compelled to cancel the holiday arrangements? Yes ☐ No ☐

I certify that the foregoing statements are correct

Doctor's Name

Doctor's Address

Doctor's Qualification

State

Postcode

Doctor's Signature X

Date / /