FULLERTON HEALTH | CORPORATE SERVICES

EMAIL: CLAIMS@FULLERTONHEALTHCS.COM.AU
PH ONE: +61 2 8256 1770
FAX: +61 2 8256 1775
LEVEL 10 / 33 YORK STREET
SYDNEY NSW 2000

TRAVEL INSURANCE REPORT AND CLAIM FORM

This form must be fully completed in the sections applicable to your claim and signed. Please ensure all supporting information is provided with your claim form otherwise there may be delays in processing.

Please keep a photocopy of all documentation you send us for your own record.

The Privacy Consent section must also be signed for all claims.

The issue of this form is not an admission of liability by the company or a waiver of its rights .

SECTION 1 - YOUR DETAILS

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Employer / Company:

Business Unit Name:

Name :

Nationality:

Address:

Address 2:

Home Phone:

Mobile Phone:

Staff / Student ?

Policy Number:

☐ Male ☐ Female Date of Birth: ☐☐/☐☐/☐☐

Country:

Work Phone:

Do you consent to us communicating with you by email? Yes ☐ No ☐

Email Address:

SECTION 2 - BANK DETAILS

Bank Details

Bank Name:

BSB (Branch): Account

Holder's Name:

IBAN Number:

Bank Address:

Account Number:

Swift Code:

Currency:

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SECTION 3 -TRAVEL INFORMATION AND AUTHORISATION

Travel Details	**Departure**	**Return**
Proposed dates of travel:	Date: ☐☐/☐☐/☐☐	Date: ☐☐/☐☐/☐☐
Actual dates of Travel:	Date: ☐☐/☐☐/☐☐	Date: ☐☐/☐☐/☐☐

Country or Countries to be Visited:

Type of Travel? (Please select one or more): Air ☐ Sea ☐ Rail ☐ Bus ☐ Hire Car ☐

Reason for Travel:

Travel Approval

This section to be completed by an Authorised Company Representative who can approve the above listed travel

Name (Last, First, M.I.): Position:

I agree that the above listed travel is authorised by my Company

Signature:

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SECTION 4 - CLAIM FOR LOSS OF PRE-PAID DEPOSITS

Does your claim arise as a result of illness, injury or accident to yourself? Yes ☐ No ☐

Does your claim arise as a result of illness, injury or accident to some other person or relative as defined in the policy? Yes ☐ No ☐

If yes, Name: Address:

Relationship: Age:

If your claim does not arise as a result of illness, injury or accident, describe the reason for your claim.

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

Has all or part of your travel been paid for? All (If all go to Q.3 below)

1. Amount of deposit paid: Date paid: ☐☐/☐☐/☐☐

2. Balance of full fare not paid: Date paid: ☐☐/☐☐/☐☐

3. Total cost of travel:

Value of forfeited portion of journey (if applicable):

Refund recevied on cancellation:

Full amount of booked travel being claimed:

Were any alternative arrangements offered ? Yes ☐ No ☐

If Yes, give details:

Did you accept any alternative arrangement?

Have you incurred any additional fares?

TOTAL AMOUNT BEING CLAIMED (you must specify the currency of your claim if not AUD)

The following items must be included with this claim. (Photocopies can be submitted . If originals are submitted keep copies)

Receipts and/or tickets relating to original and any additional expenses incurred

Proof of cause ie. Original Doctor/Hospital certificate relating to injured or sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport

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SECTION 5 - CLAIM FOR PERSONAL ACCIDENT OR ILLNESS

Does your claim arise from an accident, injury or illness while you were travelling? Accident ☐ Injury ☐

Date of accident, injury or onset of illness ☐☐/☐☐/☐☐

If illness - Type of illness, describe:

If injury - Give full details of accident, or injury occurrence:

Describe the treatment received:

Name and address of treating Doctor / Hospital / Clinic:

Date of treatment or treatments: ☐☐/☐☐/☐☐

Country / Countries where you were treated:

Amount or amounts claimed - specify currency:

If illness - have you ever suffered from the same or similiar condition in the past? Yes ☐ No ☐

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

Are you a member of a private health insurance fund? If applicable all medical accounts must first be lodged with your private health fund. Yes ☐ No ☐ Name of fund:

The following items must be included with this claim. (Photocopies can be submitted . If originals are submitted keep copies)

Original Doctor/Hospital accounts and receipts together with statements from Medicare and Private Health Funds

Original Doctors certificate, any medical, x-ray or test reports

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SECTION 6 - CLAIM FOR LOSS OR DEPRIVATION OF LUGGAGE /PERSONAL EFFECTS / ELECTRONIC EQUIPMENT / MONEY OR DOCUMENTS

Type of claim - Select one or more:

Loss ☐ Deprivation ☐ Damage ☐ Theft ☐

Time and date of the event

☐☐/☐☐/ PM ☐☐/☐☐/☐☐☐☐

Give full details of how the loss, deprivation, damage or theft occured

Was the event reported: Yes ☐ No ☐

Time and date of the report:

Reported to: ☐☐/☐☐/ PM ☐☐/☐☐/☐☐☐☐

Were articles lost or damaged by the carrier? Yes ☐ No ☐ If Yes, name the carrier:

If this is a deprivation claim - Date and time when items were returned to you

Time and date: ☐☐/☐☐/ PM ☐☐/☐☐/☐☐☐☐

* Have you made a claim or complaint against any Carrier/Airline Hotel or other authority or against any individual responsible for the loss or damage to your property? If so, attach details and copies of correspondance. **Note: The Warsaw/Montreal Convention imposes a liability upon the carrier and you should claim on them first.**

Yes ☐ No ☐

Are any of the items covered by other insurance?

Yes ☐ No ☐

If Yes, which insurer:

Policy No.

List if items claimed for:

Item Description	Name and address from where items were purchased	Original Date of Purchase	Original Purchase Price (specify currency)	Amount Claimed (specify currency)

(if insufficient space attach separate sheet)

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SECTION 7 - CLAIM FOR EMERGENCY EXPENSES DUE TO UNFORESEEN EVENT

Reason for incurring additional travel or accommodation expenses:

List the Country or Countries in which you incurred the costs

	Details	Amount Claimed
List specifically the additional **TRAVEL** expenses (Specify Currency)		
	TOTAL	

	Details	Amount Claimed
List Specifically the additional **ACCOMMODATION** expenses (Specify Currency)		
	TOTAL	

	Details	Amount Claimed
List Specifically the other **EMERGENCY** expenses (Specify Currency)		
	TOTAL	

Were these expenses incurred as a result of Injury or Sickness as claimed in Section 1? Yes ☐ No ☐

The following items must be included with this claim. (Photocopies can be submitted . If originals are submitted keep copies)

Receipts / Invoices and/or tickets relating to additional expenses incurred

Doctor / Hospital certificate specifying exact name of condition suffered by any injured/sick person

Letter form the travel agent or carrier confirming the reason for additional expenses and/or any refund applicable

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SECTION 8 - CLAIM FOR RENTAL VEHICLE EXCESS WAIVER

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

The following items must be included with this claim. (Photocopies can be submitted . If originals are submitted keep copies)

The Vehicle Rental Agreement

Notice from the rental company iin respect of the excess or deductible

Documentation evidencing payment of excess or deductible

SECTION 9 - CLAIM FOR PERSONAL LIABILITY

Bodily Injury – Provide relevant details – Name Address of injured Party and details of Injury (Use separate sheet in insufficient room)

Damage to Property – List all Property Damage together with Name and Address or Party claiming damage against you. (Use separate sheet in insufficient room)

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

Do you consider you were at fault? Yes ☐ No ☐

If so, why?

The following items must be included with this claim. (Photocopies can be submitted . If originals are submitted keep copies)

Letter or document and all details of the claim made on you.

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PRIVACY STATEMENT, MEDICAL AUTHORITY AND DECLARATION

Fullerton Health Corporate Services (FHCS)

FHCS is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). FHCS will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

FHCS will take all reasonable steps to ensure that personal information held by FHCS is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

FHCS has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.fullertonhealth.com.au and send to privacy@fullertonhealthcs.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

Medical Authority and Declaration

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

I agree to FHCS using and disclosing my personal information pursuant to FHCS'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 FHCS's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to FHCS such personal information (including health information) as FHCS in 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 cooperation to FHCS 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 if I do not consent to the terms of this authority or revoke my consent, FHCS may not be able to process or assess my claim.

I appoint FHCS 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 (any adult person): _____ Date: ☐☐/☐☐/☐☐

Name of Witness: _____