

TRAVEL INSURANCE CLAIM FORM

NEED TO MAKE A CLAIM ON YOUR COVER-MORE TRAVEL INSURANCE POLICY?

Please FULLY complete this form.
There are six steps.

OFFICE USE ONLY NEW CORRO
Claim Number:

STEP 1. PLEASE COMPLETE THIS PAGE IN FULL

A. YOUR DETAILS

*PLEASE TICK PREFERRED OPTION FOR CORRESPONDENCE. IF WE NEED FURTHER INFORMATION WE WILL WRITE TO YOU.

Title Given name/s

Family name Date of birth

Occupation

*Email address

*Residential address

Suburb

State Post code

*Postal address

Suburb

State Post code

Home phone () Work phone ()

Mobile phone *Fax ()

B. YOUR POLICY DETAILS AND TRAVEL AGENT DETAILS

Policy number Travel agent name

Consultant's name Location

Date arrangements booked Date insurance paid for

Date departed Date returned

C. OTHER INSURANCE/CLAIMS

• Do you have private health insurance? Yes No

Name of fund Policy number

• Can you claim from them for this event? Yes No
If yes, include your statement of benefits giving evidence of the amount received.

• Do you have household contents insurance? Yes No

Name of insurer Policy number

• Can you claim from them for this event? Yes No
If yes, include evidence of the amount you received.

• Have you ever made a Travel Insurance claim in the past? Yes No
If yes, please give details:

- In the last five years have you and/or any other person insured by this policy been in prison or had any criminal conviction, had insurance declined or cancelled or had a renewal refused or claim rejected? Yes No
- Certain credit cards may provide some travel insurance cover which may also cover your loss. Do you have credit card/s? Yes No
- If yes, with what provider/s and what card type/s?

Provider e.g. ANZ Type e.g. Premier Club Gold Visa

- Did you purchase your travel on the card/s? Yes No
- Can you claim/have you claimed through any other source? (e.g. airline, transport provider, travel agent, third party etc.) Yes No

Details

D. FOR GST PURPOSES - Only applies if your policy was purchased for a business

If you are entitled to an Input Tax Credit "ITC" for the GST on this policy you need to accurately advise us of this entitlement to avoid paying GST on any settlement proceeds.

The ITC on my premium is: % My ABN is:

NOTE: If you are a business and registered for GST and do not provide us with your ABN, we may have to withhold tax on payments we make under your claim.

E. EXISTING MEDICAL CONDITION COVER

• Did "Auto-Acceptance" of an Existing Medical Condition apply to you? If yes, please give details: Yes No

• Did you apply and pay for any Existing Medical Condition cover? If yes, please give details: Yes No

OFFICE USE ONLY

YOUR RIGHTS - Any concerns?

- If you are in any way dissatisfied with the way we handle or settle your claim, please direct your concerns to our Customer Service Department or the person handling your claim.
- If you remain dissatisfied please request our Claims Manager review your claim. If the concern is not resolved you have the right to have the matter reviewed by the insurance company's Internal Dispute Resolution Committee.
- If your matter is still unresolved you can have your claim reviewed by the General Insurance Claims Review Panel, an independent body which can make decisions binding on the insurance company.

COVER-MORE™ INSURANCE SERVICES - Who we are

Cover-More™ Insurance Services Pty Ltd, as handler of your claim, is acting under the authority given to us by the insurance company, and we act as agents for the insurance company and not as your agent.

WARNING TO YOU

To avoid passing the costs of dishonest and fraudulent claims on to you, our honest policy holder, by way of increased premiums and delayed settlements, we are strongly committed to promptly and thoroughly investigating claims. We try to conduct/finalise investigations quickly and with minimal disruption. All cases of fraud will be reported to the Police and can result in imprisonment.

STEP 2. WE NEED YOU TO TELL US, IN AS MUCH DETAIL AS POSSIBLE, WHAT HAPPENED.

As there are many events that might happen once you have purchased your policy, we have done our best to ensure most sections of the policy coverage are allowed for. If you need to make more than one claim please copy the relevant pages or write in the same format what happened. (Page 1 only needs to be completed once)

Date of incident	Time	AM/PM	Country	Location / Whereabouts
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

Please describe what happened and detail any action you took to recover lost/stolen items

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Were the police or a responsible authority notified? YES NO Report Reference Number

If **Yes**, state who Location Date / / Time am/pm

Do you have household contents insurance? YES NO If **Yes**, please give the name of insurance company

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

If claiming spectacles, contact lenses, dentures or hearing aids, are the items claimable through your private health fund? YES NO

If **Yes**, please submit the statement of benefit received from the private health fund showing the amount received \$

STEP 3. WHAT AMOUNTS DO YOU WISH TO CLAIM FOR?

A. OVERSEAS MEDICAL & DENTAL EXPENSES

Please list **EACH** bill / receipt separately

Name of doctor/dentist, pharmacy, hospital or provider	Date of treatment, consultation etc	Amount charged *State currency	Paid? YES or NO	Payment from Private Health Fund	OFFICE USE ONLY
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
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*Claims will be converted to Australian dollars using the currency rate applicable at the time the expenses were incurred.

Name of person/s who incurred the above amounts Date/s of birth

That person's relationship to You (the policy holder)

MEDICAL AUTHORITY: To be completed by the person whose state of health caused the claim, or the Executor of the Estate, if applicable

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for the condition/s which resulted in this claim. I acknowledge that a photostat copy of this authorisation shall be considered as valid as the original.

Signature of Patient/Executor of the Estate

Print name

Name of usual doctor or dentist in Australia (whichever is applicable)

Doctor's or dentist's phone number

Doctor's or dentist's address (include postcode)

Doctor's or dentist's fax number

If you are claiming because you cancelled or postponed your trip prior to departure, you must have the Medical Certificate below completed by the usual Doctor (General Practitioner, not specialist) of the person whose state of health/death caused your claim. If we need further information from a specialist we will ask for it later.

MEDICAL CERTIFICATE - To be obtained at the claimant's expense from the patient's usual doctor in all cases of Additional Expenses or Amendment or Cancellation Costs 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 patient

Date of birth

2. Are you the patient's usual G.P.?

Yes No

If **Yes**, for how long?

If **No**, please provide full details of the patient's usual G.P.

3 a) Please give a precise diagnosis of the illness or injury

3 b) If due to a pregnancy, on what date was the pregnancy confirmed?

4. Date of onset of illness or injury

5. Date on which you were first consulted for this condition

6. Date referred to specialist

7. Date tests prescribed

8. Date tests carried out

9. Date results advised to patient

10. Name and address of specialist/surgeon

11. Have you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in question 3? Yes No

If **Yes**, a) State if same illness or injury, or specify similar/related illness or injury?

b) When was the last time, prior to the occurrence which gave rise to this claim, and what treatment and/or medication was prescribed?

c) Was the patient advised to continue this treatment and/or medication?:

• Until departure on this journey? Yes No

• Whilst on the journey? Yes No

Yes No

d) Was the patient hospitalised? Yes No

If **Yes**, advise admission date

12. Has any other Doctor treated this patient for the same/similar illness or injury? Yes No

If **Yes**, please supply the name and address of the Doctor

13. Are you prepared to certify that solely due to the condition described in Question 3a, the claimant/s was/were required to cancel or curtail the travel arrangements? Yes No

THE FOLLOWING QUESTIONS ONLY APPLY IF THE PATIENT WAS IN THE TRAVELLING PARTY

14. How long was or will the patient be prevented from travelling?

From

To

15. Had the patient planned to travel against your prior advice? Yes No If **Yes**, please give details:

16. Did the patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment? Yes No If **Yes**, please give details:

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

Doctor's Signature

Name

Date

Qualification

Telephone

Facsimile

Address

Postcode

Cover-More™ Travel Insurance

AMENDMENT OR CANCELLATION FORM

TRAVEL CONSULTANTS:

Please complete this form for any non-refundable prepaid cancellation claim or amendment claim.

Please do not hesitate to contact our Claims Department or your Sales Executive if assistance is required completing this form.

Client's name/s

Policy/Claim number

ORIGINAL JOURNEY (DETAILS) i.e. dates, carrier, places etc.	AMOUNT PAID	AMOUNT REFUNDED	AMENDMENT COSTS	CANCELLATION COSTS
FLIGHTS (Excluding Taxes)				
FLIGHT TAXES		• Fully refundable by the airline		\$0
ACCOMMODATION				
PACKAGES				
OTHER (i.e. car hire, rail passes etc.)				
TOTAL				

IMPORTANT - ADDITIONAL DOCUMENTATION REQUIRED

- For package holidays, tours, cruises, accommodation, airfare etc we require a copy of the booking conditions showing the published cancellation/amendment conditions
- If a flight ticket or any vouchers etc are 100% NON-REFUNDABLE, the original tickets or vouchers must be sent to Cover-More with the claim documentation.
- Please attach a copy of the original itemised invoice you gave to the client on your letterhead.
- Please attach a copy of the itinerary.

ATTACHED

Yes No

Yes No

Yes No

Yes No

I certify that the information stated on this form is true and correct.

Consultant's name

Consultant's signature

Agency name and address

Date

Phone

Fax

Email

STEP 4. CHECKLIST - DOCUMENTATION YOU NEED TO SUBMIT WITH YOUR CLAIM

- This is a list of BASIC requirements. Each claim is unique and will be assessed individually. If further information, documentation or investigation is required, we will WRITE to you.
- Remember, we need you to MAIL your original claim and supporting documentation to us so please keep a copy for yourself. (Do not fax)
- **Unnecessary delays are usually experienced if you do not supply the required documentation with your fully completed claim form**

TICK

FOR ALL CLAIMS: A copy of your Certificate of Insurance must be attached. Please obtain from the agent if necessary.

A. OVERSEAS MEDICAL & DENTAL CLAIMS

- Original, itemised account/s giving a breakdown and description of amounts claimed
- If paid by credit card, a copy of the relevant statement transaction line showing the Australian dollar amount charged
- Original medical report / dental report / hospital records giving full details of the matter for which treatment was sought (Dental x-rays also)
- The Medical Authority on Page 4 must be completed by the person whose state of health caused the claim or the Executor of The Estate

B. ADDITIONAL EXPENSES

- Original, itemised hotel accommodation accounts, transport tickets and receipts for what is being claimed
- A copy of your itinerary
- If your plans changed due to your or your travelling companion's health, a medical certificate from the medical practitioner consulted (whilst on the journey) confirming the necessity to change your plans
- The Medical Authority on Page 4 must be completed by the person whose state of health caused the claim or the Executor of The Estate
- The Medical Certificate on Page 4 must be fully completed by the usual doctor/dentist of the person whose state of health or death caused this claim (whether this be the insured or any other party)
- If the claim arises from a death a full copy, not an extract, of the Death Certificate (i.e. must state cause of death)

C. AMENDMENT OR CANCELLATION COSTS

- Any relevant documentation which supports your reason for cancelling
- The form on page 5 must be fully completed by your Travel Consultant along with the requested documentation on that form being supplied
- The Medical Authority on Page 4 must be completed by the person whose state of health caused the claim or the Executor of The Estate
- The Medical Certificate on Page 4 must be fully completed by the usual doctor/dentist of the person whose state of health or death caused this claim (whether this be the insured or any other party)
- If the claim arises from the death of a person, a full copy, not an extract, of the Death Certificate (i.e. must state cause of death)

D. LUGGAGE & PERSONAL EFFECTS

- Original loss / theft report e.g. Police, hotel letter, transport provider letter etc
- If a transport provider was involved in any way; a letter from the Airline or other provider stating that the loss, theft or damage has been reported to them and what amount they will be compensating you. *Travel insurance protects you against the amount the transport provider is unable to compensate you for, subject to your policy conditions and limits. You need to claim compensation from the transport provider in the first instance before submitting your claim to us.*
- PROOF OF OWNERSHIP: Original receipts from the store where purchased. If not available, duplicates from the store should be obtained and submitted. (Other documents you may submit for consideration are warranty cards, instruction manuals, credit card/bank statements, photographs or packaging)
- Damaged Items: A quote from a repairer (of your choice) stating the repair cost and/or if the item is damaged beyond repair
- Original receipts for replacement items if you have replaced the items which were lost, stolen or damaged. (These may be stamped and returned to you if you request so in writing)
- Your original tickets and baggage tags

E. DELAYED LUGGAGE ALLOWANCE

- Original loss report from the transport provider with confirmation that all of your luggage was delayed, the length of time your total luggage was delayed and details of compensation payable by them
- Original, itemised receipts for essential, emergency purchases of clothing & toiletries (made whilst luggage was delayed)

F. RENTAL CAR INSURANCE EXCESS

- Original Rental Agreement showing the excess you were liable to pay
- Copy of the itemised repair invoice showing the cost of repairs to the vehicle
- If another party was at fault, written confirmation from them of the compensation payable by them

G. LOSS OF INCOME

- Original Medical Certificate from your doctor stating your inability to work including the start & finish dates of this period
- Letter from your employer (or Accountant if self-employed) stating the date you were to return to work and your nett monthly wages
- Two recent pay slips

STEP 5. SIGNING YOUR DECLARATION

I/We declare that all statements and particulars contained on this claim form and all documents submitted are true and correct. I/We acknowledge that the underwriter or it's agents may give to and obtain from any other insurer or insurance reference bureau, information relating to this or any other insurance held by Me/Us, or any claim made by Me/Us and I also authorise any other insurer to provide information relating to this or any claim made by me.

Signature of Policy Holder

Date

Signature of Policy Holder

Date

STEP 6. POST YOUR CLAIM TO US (do not fax)

- Please ensure you keep a copy of your claim.
- Please post your original claim to: **COVER-MORE INSURANCE SERVICES, CLAIMS DEPARTMENT, PRIVATE BAG 913, NORTH SYDNEY NSW 2059.** If you need any help please contact us on **Ph: 1300 362 644 or (02) 8907 8099.**
- *Thank you for taking the time to fully complete this form and supply all the documentation and information requested. We aim to respond in approximately two weeks (not including Public Holidays and weekends) from when we receive your claim.*