

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 077 522

Fax: (07) 3305 7016

Email: travelclaims@mondial-assistance.com.au

Postal Address:

Worldcare 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 077 522 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.

2. Are you a member of any private health fund? YES NO

If yes, name of fund: Membership number:

b) Can you claim any of your expenses from any private health fund? YES NO

If yes, include health fund statement of benefits as evidence of the amount received from the private health fund.

3. If you are claiming for additional expenses, what were your original expected plans for accommodation/transport for the period for which you are claiming and how were the expenses being claimed additional to your original expected costs?

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.....
.....

4. If you are claiming for cancellation charges, on what date were your travel arrangements cancelled: /..... /.....

MEDICAL EXPENSES	AMOUNT CLAIMED (state currency)
.....
.....
.....
.....
	Sub total
	Less private health fund benefits
	Total medical expenses
ADDITIONAL TRANSPORT AND ACCOMMODATION EXPENSES
.....
.....
.....
.....
CANCELLATION CHARGES
.....
.....
.....
.....

To be completed by the person whose state of health caused the claim:

I authorise the underwriter 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 photocopy of this authorisation shall be considered as valid as the original.

Signature of patient: Print Name:

Name of usual doctor in Australia: Doctor's phone number: ()

Doctor's address: Postcode:

IMPORTANT: DOCUMENTS REQUIRED TO PROCESS YOUR CLAIM

- | | |
|--|--------------------------|
| Medical Expenses | Attached (✓) |
| a) Original medical accounts | <input type="checkbox"/> |
| Additional Expenses | |
| a) Original hotel accommodation accounts | <input type="checkbox"/> |
| b) Original transport tickets and receipts | <input type="checkbox"/> |
| c) Medical Certificate from the doctor / dentist you consulted on your journey supporting the need to change your travel plans | <input type="checkbox"/> |
| Cancellation Charges | |
| a) Travel agent's letter detailing cancellation charges. This should show amounts paid for your travel and amounts refunded | <input type="checkbox"/> |
| b) Original tickets/vouchers/passes if they are completely non-refundable | <input type="checkbox"/> |
| c) Medical Certificate (on page 4) from the doctor / dentist you consulted on your journey supporting the need to cancel your travel plans | <input type="checkbox"/> |

OTHER CLAIMS

- If you are claiming under a section of the policy not provided for on this claim form, please provide details below.
- We recommend that you contact us for advice on the documents required to support your claim.

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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: ()