Global Assistance

Allianz

Corporate Travel and Personal Accident Insurance Claim Form

Prepared 03 January 2012

Email: travelclaims@allianzassistance.com.au
Phone: 1800 761 173
Facsimile: (07) 3360 7854

Postal Address:

Claims Department
PO Box 162
Toowong QLD 4066
Australia

Claim No:

Important: please read before you complete this form

- Please answer all questions and provide all relevant documentation to avoid delays with the claim. We are unable to process any claims until all information requested on this form is provided.
- When completing this form please print using black or blue ink.
- Some words used below that start with a capital letter have a special meaning as defined in the Corporate Travel and Personal Accident Insurance Product Disclosure Statement (including Policy Wording) and such other documents as make up the Policy which contain definitions, unless a specific definition is set out below, in which case it will take precedence
- The issue of this form is not an admission of liability by us.

YOUR DETAILS - COMPULSORY

Policy and Claimant Details

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Policy Number ☐☐☐☐☐☐☐☐☐☐☐☐ Period of Insurance end date ☐☐ / ☐☐ / ☐☐

Name of Insured

If this claim is as a result of death, please provide:

Name of the deceased's Estate or Legal Representative

Deceased's date of birth, occupation and business

Name of Insured Person the subject of the claim (Claimant) (Mr/Mrs/Miss/Ms)

Address of Claimant

Postcode State or Territory Country of Residence

Telephone: Home Business Mobile

Email Address

Date of Birth ☐☐ / ☐☐ / ☐☐ Occupation

Name of Broker (if known)

Are you an employee of the Insured? Yes ☐ No ☐ Date of Departure ☐☐ / ☐☐ / ☐☐

Was this authorised business travel? Yes ☐ No ☐ Date of Return ☐☐ / ☐☐ / ☐☐

Are you able to claim through any other source? Yes ☐ No ☐

If yes, please provide details: ______________________________

Have the Claimant made previous travel insurance claims? Yes ☐ No ☐ If *Yes*, please complete table below.

Date of Claim	Name of Insurer	Claim Number	Details of Claim	Amount Claimed	Amount Paid

PAYMENT DETAILS - COMPULSORY

Please tick your preferred form of payment for refund

☐ Direct/EFTPOS ☐ Cheque Payee

Name of Bank

Branch: Account Holder

BSB Number: - Account Number:

Provide your bank details below for a direct credit to your nominated bank account. Please note we cannot deposit into a credit card account.

If we are required to make a payment on a Claimant's behalf no payments will be made on the Claimant's behalf until we receive payment of any applicable excess.

GST information

Must be completed by the Financial Controller of the Insured **ONLY** for:

- each company-owned item
- any other expenses where Australian GST is incurred by the Insured.

Are you registered for GST Purposes? Yes ☐ No ☐

What is your Australian Business Number (ABN)?

Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? Yes ☐ No ☐

If yes, what percentage of the GST did you claim or are you entitled to claim? %

(Please note, if the GST paid and your ITC entitlement are the same amounts, the answer to this question is 100%)

CLAIM INFORMATION - PLEASE COMPLETE THE RELEVANT SECTION/S

A. Personal accident or death claim

The following items must be included with this claim:

- medical/hospital report/s detailing the Claimant's treatment, diagnosis and outcome,
- completed Medical Certificate (see last page of claim form),
- if this claim is as a result of death - a copy of the deceased's Death Certificate and the Coronor's Depositions and Findings (if applicable).

Details of Injury, Sickness or death

Cause of death (if applicable)

Date of Accident from which the injury or death occurred / /

Date of first medical consultation / / Name of Medical Practitioner and/or hospital

Details of other treatment by Medical Practitioner and/or hospital

Final Diagnosis and outcome

Dates in hospital: Admitted: / / am/pm Discharged: / / am/pm

Was Allianz Global Assistance contacted? Yes ☐ No ☐

Has the Claimant ever suffered from the same or similar injury or sickness in the past? Yes ☐ No ☐

If yes, provide details including dates, names and addresses of treating Medical Practitioner:

Date of death (if applicable) / / Time am/pm

Was a coronial inquest held or is one to be held? Yes ☐ No ☐

If yes, provide details:

B. Overseas medical, dental and/or hospitalisation Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Medical/hospital/dental report detailing treatment and diagnosis,
- Itemised accounts giving a breakdown and description of costs claimed, together with receipts if any accounts have been paid (please note that all medical and hospital accounts incurred within Australia must first be submitted to Medicare for refund, and also the the Claimant's private health fund, if applicable),
- Completed Medical Certificate (see last page of claim form).

Type of Injury or Sickness Date of Accident or commencement of Sickness / /

If injury - Give full details of Accident

Date of first medical/dental Consultation / /

Name of Medical Practitioner and/or Hospital

Details of other treatment by medical practitioner and/or hospital

Dates in Hospital - Admitted / / am/pm Discharged / / am/pm

Was Allianz Global Assistance contacted? Yes ☐ No ☐

Have you ever suffered from the same or similar injury or sickness in the past? Yes ☐ No ☐

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

Please list each receipt/bill separately in the table below. Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

Name of Doctor/Dentist/Pharmacy/ Hospital or Provider	Treatment Performed	Date of Treatment	Amount Charged (State Currency)	Paid Yes/No	Refund from Health Funds

C. Additional Expenses Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Copy of orginal Itinerary,
- Receipts, bank statements and/or credit card statements showing amounts paid for original Itinerary,
- Proof of payment for additional expenses claimed (ie. tax invoices, receipts, credit card/bank statements showing payments made),
- If the additional expenses were incurred due to a transport provider - letter from them explaining circumstances and any compensation paid or payable,
- If the additional expenses were incurred due to medical reasons or death - a completed Medical Certificate (see last page of claim form) and copy of the Death Certificate (if applicable).

What was the unexpected expense incurred?

Please state the reason/event that caused the additional expenses being incurred

If the claim arose as a result of an Injury, Sickness or death, please provide the name of the person whose Injury, Sickness or death necessitated the additional expenses to be incurred:

Name and relationship to Claimant Date of birth / /

Address (if not Claimant)

Please list each receipt/bill separately in the table below. Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.

Date of Expense	Description of Expense	Amount	Date of Original Plan	Description of Original Cost	Amount

D. Luggage and Personal Effects Claim

1. Claim for delay or misplacement of luggage by a carrier

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Itemised receipts for the purchase of essential items,
- Property Irregularity Report from the carrier (bus line, airline, shipping line or rail authority) and confirmation of any compensation paid,
- Ticket and baggage tags from the carrier that caused the luggage to be delayed or misplaced.

Name of carrier that delayed or misplaced the luggage: ☐

Date delay or misplacement occurred: ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm Location/country ☐

Date delay or misplacement occurred: ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm Location/country ☐

Delay or misplacement reported to: ☐

Property Irregularity Report number: ☐

Date luggage was returned: ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm Location/country ☐

Has claim or complaint been lodged against the carrier that was responsible for the delay or misplacement? Yes ☐ No ☐

If yes, please provide details in the table below and attach copies of correspondence.

Carrier	Claim Number	Amount of compensation paid

Please complete the below schedule in full for any essential items which have been purchased. Claims will be converted to Australian dollars using the currency rate applicable at the date the expenses were incurred.

Description of essential items purchased	Date of purchase	Price paid	Store where item was purchased	Receipt attached Yes/No

2. Claim for loss (including theft) or damage

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Proof of ownership of the item/s claimed (tax invoices, receipts, credit card statements and bank statements proving purchase of the item/s),
- Report made to the transport provider, police, hotel or other appropriate authority,
- If the claim is for damage to items - an estimate of repairs where feasible, or written confirmation from a competent repairer or dealer that the item/s are damaged beyond economic repair.

Give full details of how losses, damage or thefts occurred: (Detail each event)

Date loss/damage occurred: ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm Location/country ☐

Date loss/damage occurred: ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm Location/country ☐

Loss/damage reported to (police, airline or other authority): ☐

Police report number or event number: ☐

Were items lost/damaged by carrier? (e.g. Airline) Yes ☐ No ☐ Name: ☐

Have you lodged a claim or complaint against any carrier, airline or other authority or against any individual responsible for the loss or damage of the items? Yes ☐ No ☐

(a) If yes, please provide details in the table below and attach copies of correspondence.

(b) If no, please lodge a claim with the relevant carrier before submitting this claim to us.

NOTE: The 1999 Montreal Convention imposes a liability upon Airlines and you should claim from them first.

Carrier	Claim no.	Amount of compensation paid

What action was taken to recover lost items?

Are any of the items covered by other insurance? Yes ☐ No ☐

If Yes - Which company ☐ Policy Number ☐

Were all the missing items the Claimant's property? Yes ☐ No ☐

If no, provide details of the owner

Full description of lost/damaged items (including details of damage where applicable)	Store From Where Item Was Originally Purchased	Original Date of Purchase	Original Purchase Price	Has item been replaced Yes/No	ITC %	Amount Claimed (AUD)

3. Claim for loss or theft of travel documents, credit cards, traveller's cheques or money

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Report made to police, transport provider, hotel or other appropriate authority,
- Confirmation from credit card provider, bank or Department of Foreign Affairs & Trade (DFAT) of loss and/or cancellation of travel documents, credit cards or traveller's cheques.

Provide full details of how losses, damage or thefts occurred: (Detail each event)

Date loss/damage occurred: ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm Location/country ☐

Date loss/damage occurred: ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm Location/country ☐

Loss/damage reported to (police, airline or other authority): ☐

Police report number or event number: ☐

Description of items	Date of cancellation	Replacement/reissue cost	Amount claimed

E. Cancellation Charges / Loss of Deposit Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

- Copy of original Itinerary.
- Terms and Conditions issued by Travel Agent and/or Transport, Tour or Accommodation Provider,
- Letter from Travel Agent or, where travel was not arranged through a Travel Agent, a letter from the relevant organisation through whom travel was booked, confirming payments made, refunds given and any amounts out of pocket,
- Proof of payment for trip (i.e. receipts, credit card/bank statements showing payments made),
- If travel was cancelled by a Transport Provider - letter from them explaining the circumstances of the cancellation and any refund/ compensation paid or payable,
- If travel was cancelled due to medical reasons or death - completed Medical Certificate (see last page of claim form) and copy of Death Certificate (if applicable).

Date travel arrangements booked: ☐☐ / ☐☐ / ☐☐ Date of cancellation ☐☐ / ☐☐ / ☐☐

Please provide the reason why the proposed Journey could not commence or be completed: __________

If the Journey was cancelled as a result of Injury, Sickness or death, please provide the name of the person whose Injury, Sickness or death resulted in the cancellation of the Journey:

Name and relationship to Claimant ☐ Date of Birth ☐☐ / ☐☐ / ☐☐

Address (if not claimant) ☐

Relationship ☐ Nature of Injury/Sickness ☐

Details of Journey

Date	Description of Booking	Supplier	Amount Paid	Refund Received	Amount Claimed

F. Rental Vehicle Excess Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- **Copy of your rental vehicle agreement.**
- **Copy of the repair invoice if claim is due to the rental vehicle being damaged.**
- **Copy of documents showing amount debited by rental vehicle company for damage or excess.**
- **Report made to the police or other appropriate authority.**

Date of incident ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm

Location of accident/incident ☐

Rental vehicle company name ☐ Country where the vehicle was rented: ☐

Please state in full, exactly what happened (if necessary, a diagram may be used to depict the event) __________

Was the damage due to a collision with another vehicle? Yes ☐ No ☐

If Yes, please provide the name and address of the person who was driving the other vehicle involved in the collision

☐

Please provide the registration number of the other vehicle ☐

Please provide the name and address of the insurer of the other vehicle: __________

Did police attend the incident? Yes ☐ No ☐ Who was at fault? ☐

Repair costs ☐ Date the damage was paid for ☐☐ / ☐☐ / ☐☐

Excess which was required to be paid ☐ Amount being claimed ☐

Has any compensation been received from any person or party involved in the accident or incident? Yes ☐ No ☐

If Yes, please state the amount received ☐

G. Other

PLEASE PROVIDE ANY INFORMATION AVAILABLE TO SUPPORT THIS CLAIM.

Date of incident ☐☐ / ☐☐ / ☐☐ Time ☐ am/pm

Location of accident/incident ☐

Please tell us in as much detail as possible what happened to you in order for you to make this claim. Be as specific as possible, including dates and amounts paid. If there is not enough room in the space provided, you may continue your description of the events on a separate piece of paper.

Claim No: ________________

Policy No: ________________

Email: travelclaims@allianzassistance.com.au

Global Assistance

Allianz

MEDICAL AUTHORITY AND DECLARATION

Allianz Global Assistance is authorised by the insurer Allianz Australia Insurance Limited (Allianz) ABN 15 000 122 850 AFS Licence No. 234708 to act as their agent and deal with and settle any claims in relation to Sections 1 to 13 of the Policy.

Claims under Section 14 of the Policy are dealt with by the insurer Allianz Australia Life Insurance Limited (Allianz Life) ABN 27 076 033 782 AFS Licence No. 296559. Allianz Global Assistance collects information in this form as agent of Allianz Life but is not authorised to settle any claims in relation to Section 14 of the Policy.

DISPUTE RESOLUTION PROCESS

If you have a complaint or dispute in relation to this insurance, or the services of Allianz Global Assistance or its representatives, please call Allianz Global Assistance on 1800 761 173 or put the complaint in writing and send it to The Dispute Resolution Department, PO Box 162, Toowong, Queensland 4066. Allianz Global Assistance will attempt to resolve the matter in accordance with its Internal Dispute Resolution process. To obtain a copy of Allianz Global Assistance's procedures, please contact them.

A dispute can be referred to the Financial Ombudsman Service Limited (FOS), subject to its terms of reference. The FOS provides a free and independent dispute resolution service for consumers who have general insurance disputes falling within its terms. The contact details for the FOS are:

Financial Ombudsman Service Limited (FOS)
GPO Box 3, Melbourne VIC 3001
Phone: 1300 780 808
Fax: (03) 9613 6399
Website: www.fos.org.au
Email: info@fos.org.au

Privacy: The Privacy Act 1988 requires us to tell you that Allianz Global Assistance acts as an agent for Allianz and Allianz Life to collect personal information in order to handle this claim. We may disclose this personal information to third parties such as other insurers, travel agents, medical practitioners, intermediaries, loss adjusters, external claims data collectors, investigators and the Insurance Reference Services (IRS), or as required by law. You and the Claimant have the right to seek access to such personal information at any time. Please contact Allianz Global Assistance on 07 3360 7851 for access.

I DECLARE THAT:

- I will use my best endeavours and render all reasonable assistance and co-operation to Allianz Global Assistance and Allianz Life in the assessment of my claim;
- The information supplied by me is true and correct and I have not withheld any information likely to affect the assessment of my claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proofs of my claim, Allianz Global Assistance and Allianz Life have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy;
- A photocopy of this Authorisation shall be considered as effective and valid as the original and I specifically authorise its use as such.

I appoint Allianz Global Assistance and Allianz Life to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as Allianz Global Assistance and Allianz LIfe in their absolute discretion consider relevant for their assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);
- my Health Insurance claims history, including Medicare;
- any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

Signature of Claimant (or authorised representative) .... Date ☐☐ / ☐☐ / ☐☐

Name of Claimant ....

Name of authorised representative (where relevant) ....

Signature of the Insured (or authorised representative) .... Date ☐☐ / ☐☐ / ☐☐

Name of the Insured ....

MEDICAL CERTIFICATE

To be completed by the patient's usual Medical Practitioner (at the Claimant's expense) in all cases of cancellation and medical claims resulting from Accident, Sickness or Death.

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

________________ Date of Birth ☐☐ / ☐☐ / ☐☐

Address ________________ Postcode ________

Instructions to the Medical Practitioner:

Please complete this form in block letters, and provide as much information as possible in order to assist our client and avoid any additional enquiries:

1. (a) Are you the patient's usual Medical Practitioner? Yes ☐ No ☐ If yes, for how long? ________
   (b) If no, do you have access to their medical records? Yes ☐ No ☐

The claimant must indicate (by ticking the relevant box) which is applicable, question 2 or 3. If this claim relates to a death benefit (section 14 of the policy) please complete question 3.

☐ 2. Alteration to/cancellation of travel arrangements prior to travel.

(a) Did you recommend that travel be cancelled or postponed due to the patient's state of health? Yes ☐ No ☐

(b) On what date did you make this recommendation? ☐☐ / ☐☐ / ☐☐

(c) Please give precise details of the nature of the sickness or injury which gave rise to this recommendation (including the final diagnosis)

____

____

(d) Did you fully explain the risk of travelling with this medical condition? Yes ☐ No ☐

(e) On what date did the patient first become aware of their symptoms? ☐☐ / ☐☐ / ☐☐

(f) Please describe the symptoms advised by the patient.

____

____

(g) On what date were you first made aware of the condition, or change in the condition? ☐☐ / ☐☐ / ☐☐

(h) Has the patient previously been investigated, diagnosed or treated in respect to the same/similar/related sickness or injury? Yes ☐ No ☐

If Yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

(i) Did the patient make the travel arrangements against your advice (or the advice of another medical practitioner)? Yes ☐ No ☐

OR

☐ 3. Treatment costs/ additional expenses incurred during travel.

(a) What do you understand to be the sickness or injury which resulted in the need to seek medical care/ interrupt the patient's travel plans?

____

____

(b) Has the patient previously been investigated, diagnosed or treated in respect to the same/similar/related sickness or injury? Yes ☐ No ☐

If Yes, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

(c) Was there any indication that medical care may be required on the journey? ________

(d) Was the patient non-compliant with medical advice whilst on the journey? Yes ☐ No ☐

(e) Did the patient travel against your advice (or the advice of another medical professional)? Yes ☐ No ☐

For death benefit claims only

(f) Had the patient been treated for any medical condition which directly or indirectly caused their death? Yes ☐ No ☐

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

Doctor's Signature ________ Date ☐☐ / ☐☐ / ☐☐ Doctor's Stamp ________