

## TRAVEL INSURANCE CLAIM FORM

OFFICE USE ONLY – CLAIM NO:

**PLEASE READ THE CLAIM FORM CAREFULLY.**

- The issue of this claim form does not constitute an admission of liability
- Omission of relevant information may delay your claim

### INSURED DETAILS

Certificate No:		Insurance Company:	
Given Name:		Surname:	
Date of Birth:		Occupation:	
Address:			
Suburb		State and Postcode:	
Daytime Ph:		Mobile No:	
Email Address:			

### HOLIDAY/TRIP DETAILS

Date holiday/travel was booked			
Country (where event occurred)			
Date of Departure:		Date of Return:	

### DESCRIPTION OF CIRCUMSTANCES LEADING TO CLAIM

Describe fully the circumstances of the incident, which has led you to make the claim(s):

**NOTE:** It is vital that you explain as carefully as you can, the specific circumstances leading up to and following the incident. Please continue on a separate page if insufficient space.


Please read the following carefully and then complete the appropriate section relevant to what you wish to claim for. Please note if you are claiming for various incidents then you will need to ensure that the appropriate sections are completed accordingly.

If you are claim form	Please complete sections
Cancellation or postponement of trip	A & Med. Certificate
Medical, Emergency Dental, Hospital and/or Other Expenses relating to a medical incident <b>and/or</b> Expenses incurred due to Curtailment (Early return home from your trip)	B & Med. Certificate
Personal Liability	C
Missed Departure, Delayed travel or Abandonment of your trip due to Delayed Travel	D
Loss, theft or damage to Baggage (including delayed baggage), Valuables, Money and Documents	E & I
Costs incurred due to Catastrophe	F
Collision Damage Waiver Excess (Damage to Rental Vehicle)	G
Additional Expenses incurred or any other incident not outlined above	H & I

## A. CANCELLATION OR POSTPONEMENT OF YOUR TRIP

Date on which you cancelled/postponed your trip with Tour Operator/Travel Agent/Airline:

**Trip cancelled for Medical Reasons – Note: The regular medical practitioner of the ill/injured/deceased person must complete the attached certificate.** ☐

Full name of ill/injured/deceased person

**Trip cancelled for non-medical reasons – Supply evidence to support the reason** ☐

Name of all persons cancelling or postponing this holiday, (including the claimant), and their relationship to the ill/injured/deceased person: -

Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>

Total amount paid for trip (excluding insurance premiums): \$

Refund received from (  ): \$

Amount Claimed: \$

## B. MEDICAL, EMERGENCY DENTAL, HOSPITAL AND/OR OTHER EXPENSES RELATING TO A MEDICAL INCIDENT

Full name of persons who's (tick applicable) ☐ injury ☐ illness ☐ death resulted in the expenses claimed

Relationship to those travelling?

Was the person named booked to travel?

Date of onset of illness/injury:

Were there any other persons who in your opinion were responsible for the injury? Yes ☐ No ☐

If yes, please give full details:

Give details of treating Doctor: Name:

Was the Medical Emergency Assistance Company advised of the incident? Yes ☐ No ☐

Date:  If No, state why not:

Was the ill/injured person hospitalised? Yes ☐ No ☐

If yes, Date of admission:

Date of discharge:

Give details of treating hospital: Name:

Did the Medical Emergency Assistance Company authorize the hospitalisation? Yes ☐ No ☐

Period of enforced extended residence, other than in hospital (if applicable):

Name/Address:

Period: From:

To:

## CURTAILMENT DETAILS (IF APPLICABLE)

Identify all persons for who emergency expenses have been incurred:

Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>
Name:	<input type="text"/>	Relationship:	<input type="text"/>

Date of early return to Country of Residence:

Did the Medical Emergency Assistance Company authorize the Curtailment? Yes ☐ No ☐ n/a ☐

Total cost of holiday (excluding insurance premiums): \$

Total Number of Nights: \$

Refund allowed to you by Travel Agent/Tour Operator: \$

## MEDICAL HISTORY

Has the ill/injured person suffered from the same/similar condition before? Yes ☐ No ☐

If yes, please give details and date of consultations:

Do you hold any private health insurance or other insurance, which may cover this claim? Yes ☐ No ☐

If yes, please provide details of Insurance Company and Policy Number:

Have you previously made any claim in respect of medical, or curtailment expenses? Yes ☐ No ☐

If yes, please give brief details:

Details of Expenditure	Date Costs Incurred	Cost incurred & Currency	For which Insured was cost incurred?	Paid by yourself YES/NO	Office use only
Doctor's Fees					
Hospitalisation					
Prescription/Medication					
Ambulance					
Emergency Dental Treatment					
Additional Hotel Expenses					
Additional Travel Expenses					
Repatriation of body in event of death					
Cost of burial or cremation abroad					
TOTAL AMOUNT CLAIMED					

## C. PERSONAL LIABILITY

Full Name of person who alleged actions have resulted in the expenses of claimed:

Full Name/Company Name of the Third Party whom have deemed you liable for the same alleged actions:

Contact Details for the Third Party

Address:  Contact No

Relationship of the above Third Party to the Insured, if any?

What are the expenses related to?

☐ Accidental Bodily injury ☐ Accidental Damage to Property

☐ Other

Please Detail

Where there any other persons who in your opinion were responsible for the incident? Yes ☐ No ☐

If yes, please give full details: -

Were the Police contacted following the incident? Yes ☐ No ☐

If yes, please provide a Police report.

Identify all persons for whom expenses have been incurred:

Name:

Details of Expenditure	Date costs incurred	Costs incurred & Currency	Paid by yourself YES/NO	Office use only
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

#### D. DELAYED TRAVEL OR ABANDONMENT OF YOUR TRIP DUE TO DELAYED TRAVEL /MISSED DEPARTURE

##### DELAYED DEPARTURE

What was the reason for the delay?

As a result of the delay did you decide to abandon your holiday? Yes ☐ No ☐

If yes, please advise the following:

Cost of holiday (excluding Insurance)	\$ <input type="text"/>
Refund made by the Travel Company	\$ <input type="text"/>
Amount Claimed	\$ <input type="text"/>

Please list all persons claiming

State the total time you were delayed: Hours:  Minutes:

##### MISSED DEPARTURE

Were the original arrangements paid for in advance? Yes ☐ No ☐

Have you ever received any refund of this sum? Yes ☐ No ☐ If yes, state amount: \$

If due to own vehicle breakdown, please give following details:

Car Make:  Model:  Registration:

What was the problem with the vehicle?

##### TRAVEL ARRANGEMENT DETAILS

Travel Itinerary/Schedule as originally booked		Amended Travel Schedule as a result of delay	
Departing from (place)	<input type="text"/>	Departing from (place)	<input type="text"/>
Time and Date	<input type="text"/>	Time and Date	<input type="text"/>
Arriving at (place)	<input type="text"/>	Arriving at (place)	<input type="text"/>
Time and Date	<input type="text"/>	Time and Date	<input type="text"/>

#### E. LOSS, THEFT OR DAMAGE TO BAGGAGE (INCLUDING DELAYED BAGGAGE), VALUABLES, MONEY AND DOCUMENTS

At what place, date and time was the property last seen and know to be undamaged:

Place:  Date:  Time:

Place:  Date:  Time:

Place where in your opinion the loss, damage or theft occurred.

Did the loss or damage occur whilst in the custody of Airline, Coach Company, Railway, Hotel etc? Yes ☐ No ☐

If yes, Name and Address of Company:

Have you held them responsible in writing of loss/damage/delay? Yes ☐ No ☐

If no, state why not?

##### If Airline involved:

Sate Flight No:  From (Airport):

Did you obtain a Property Irregularity Report from the Airline: Yes ☐ No ☐ n/a ☐

If no, state why not?

**If loss from hotel room or vehicle:**

Was the hotel room or vehicle locked? Yes ☐ No ☐ n/a ☐

Where was the key?

How was entry made?

Was loss from hotel safe/deposit box? Yes ☐ No ☐ n/a ☐

Did you report the loss to the Hotel Manager: Yes ☐ No ☐ n/a ☐

If no, state why not?

**All loss/theft**

Did you report the loss to the Police? Yes ☐ No ☐ N/a ☐ Date Reported:

Address of Police Station:

If no, state why not:

Please state fully the action taken to recover lost property:

  
  
  


Have you made contact since to check if property recovered? Yes ☐ No ☐ n/a ☐

If no, state why not:

If yes, what was the result:

If property was returned to you, please state:

Place:  Date:  Time:

Total time the baggage was delayed? Hours:  Minutes:

Are you to owner of all the lost/stolen/damaged items? Yes ☐ No ☐

If no, state: Item/s  Owner:

Relationship to you:

Were any of the lost/stolen/damaged items given to you as a gift? Yes ☐ No ☐

If yes, state: Item/s:

**Please note if you have named any Valuables as gifts:** If possible, we request that you obtain a Statutory Declaration from the person who gave you the items, detailing the date, cost and place of purchase to prove ownership. If you have alternative proof of purchase, this is not required.

If you have previously sustained theft/loss/damage of luggage, clothing, personal effects, valuables, money; please give brief details and the appropriate date and amount of loss:

**F. COSTS INCURRED DUE TO CATASTROPHE**

Onset of Catastrophe: <input type="text"/>	
Name: <input type="text"/>	Relationship: <input type="text"/>
Name: <input type="text"/>	Relationship: <input type="text"/>
Name: <input type="text"/>	Relationship: <input type="text"/>
Name: <input type="text"/>	Relationship: <input type="text"/>
Name: <input type="text"/>	Relationship: <input type="text"/>

Please give specific details of any irrecoverable expenses or additional expenses incurred as a result of the catastrophe:

Full description of expense	Currency and Amount paid	Office Use Only
<input type="text"/>	<input type="text"/>	<input type="text"/>
<b>TOTAL AMOUNT CLAIMED</b>	<input type="text"/>	<input type="text"/>

## G. COLLISION DAMAGE WAIVER EXCESS (DAMAGE TO RENTAL VEHICLE)

At what place, date and time was the vehicle **last seen and known to be undamaged**:

Place:  Date:  Time:

At what place, date and time was the vehicle **discovered missing or damaged**:

Place:  Date:  Time:

Please where in your opinion the damaged occurred:

Did the loss or damage occur whilst in the custody of another party (i.e. other than the Insured/s) or were there any other person who in your opinion were responsible for the damage? Yes ☐ No ☐

If yes, Name and Address of party:

Have you held them responsible in writing for loss/damage?

Yes ☐ No ☐

If no, state why not

If damage to inside of vehicle (eg. attempted theft of stereo etc.) was vehicle locked? Yes ☐ No ☐

Where was the key?

How was entry made?

Did you report the damage to the Police?

Yes ☐

No ☐

n/a ☐

Date

Address of Police Station:

If no, state why not:

Please state fully the action taken to minimise the damage:

### Rental Agreement Details

Name of Hire/Rental Vehicle Company	Amount of Hire/Rental vehicle insurance policy excess / damages (\$) (with currency)	Has this been paid by you? If no, why not? If yes please attach receipt.	Amount Claimed (with currency)	Office use only
<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>	<input style="width: 100%;" type="text"/>

Have you previously made a claim for damage to a hire/rental vehicle? Yes ☐ No ☐

If yes, please provide details:

## H. Additional Expenses incurred or any other incident not outlined above

Date of event leading to additional expenses incurred:

Name all persons who incurred irrecoverable additional costs (including claimant):

Name:	<input style="width: 100%;" type="text"/>	Relationship:	<input style="width: 100%;" type="text"/>
Name:	<input style="width: 100%;" type="text"/>	Relationship:	<input style="width: 100%;" type="text"/>
Name:	<input style="width: 100%;" type="text"/>	Relationship:	<input style="width: 100%;" type="text"/>
Name:	<input style="width: 100%;" type="text"/>	Relationship:	<input style="width: 100%;" type="text"/>
Name:	<input style="width: 100%;" type="text"/>	Relationship:	<input style="width: 100%;" type="text"/>

I. ITEM / EXPENSE DETAILS						

If claiming for lost/stolen/damaged items, complete all columns. If claiming Delayed Baggage, complete columns, 1, 3, 4, and 7. If Claiming for additional Expenses, completed columns 1 and 7. Reimbursement will be based on the value of the property at the time of loss or damage. (Please continue on separate page, if insufficient space)

[illegible]

## DECLARATION

- ☐ I/We have completed the Claim form and declare it to be true and accurate and am enclosing the documents as requested to support this claim. I subrogate to my Insurer all rights of recovery/salvage against any person or organization and will do whatever else is necessary to secure such rights. With regards to any MEDICAL, CURTAILMENT & EMERGENCY CLAIMS I give authority to Insurers or their representatives to contact my Doctor if need be, for any additional medical information required in connection with this claim. I authorise any hospital, physician or other person who attended me, to give my travel insurance company or its representative, any, or all information, with respect to any sickness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I agree that a photocopy of this authorization will be considered as effective and valid as the original.

## BANK ACCOUNT DETAILS

- ☐ I/We authorise Gallagher Bassett to transfer any settlement amount into the account outlined below.
- ☐ I/We have the consent of each person who is insured on this Policy and making a claim in relation to this event (if they have been included in this claim form) for settlement monies to be transferred into the below account.
- ☐ I/We acknowledge that payment of any unpaid accounts will be issued to the provider.

BSB Number:    -    Branch Name:

Account Number:           Account Name:

Name:  Date:

**When you have completed the appropriate sections and agreed to the above, please send claim form & all supporting documentation to:**

**Gallagher Bassett  
Travel Claims Department**

**POST: GPO Box 14, Brisbane,  
QLD 4001**

**FAX: 00 61 (7) 3005 1705**

**EMAIL:  
brisclaims@gbtpa.com.au**

### **Please Note:**

- **We are happy to accept your claim form via any of the left, however please note that in all cases, we require you to provide all supporting documentation.**
- **Once we have received your claim form we will make contact with you within five (5) working days. At this stage we may request further information in order to proceed with your claim.**
- **We recommend you keep a copy of the completed form and documentation for your own records.**

**If you still have any queries regarding the claim process, please contact us via our email address, or  
Ph: 00 61 (7) 3005 1613**



## REQUIRED DOCUMENTATION TO BE SUBMITTED WITH CLAIM

### A. Cancellation or postponement of trip

Receipt of payment for flights/trip,  
 Booking conditions of flights/trip,  
 Letter from Airline(s)/Tour Operator(s)/Accommodation Provider(s) confirming amount of refund(s)  
 Airline Tickets/Prepaid tickets  
 If Cancellation/Postponement is due to Medical reasons, the attached Medical Certificate is to be completed by the regular medical practitioner of the ill/injured/deceased person,  
 If cancellation/Postponement is not due to Medical reasons, provide full evidence to support the requirement to Cancel or Postpone,  
 Full Death Certificate (if applicable),

### B. Medical, Emergency Dental, Hospital and/or Other Expenses relating to a medical incident and/or Expenses incurred due to Curtailment (Early return home from your trip)

Original receipts and/or invoices for all Hospital/Doctors/Dentist/Chemist/Additional Expenses claimed,  
 Medical Certificate from the Doctor or Hospital that treated the ill/injured person,  
 Full Death Certificate (if applicable)

### C. Personal Liability

Receipts of any expenses outlaid,  
 Documentation from Third Party detailing the costs they are pursuing and why, i.e. Letter of Demand,  
 Police Report (if applicable).

### D. Missed Departure, Delayed travel or Abandonment of your trip due to Delayed Travel

Travel Itinerary detailing all stages (departure and arrival times) of your Trip,  
 Written confirmation from the airline/tour operator or similar of, detailing the reason for delay and subsequent departure times, **Travel Delay**  
 Bills, invoices and receipts for additional amounts claimed, **Missed Departure**  
 Certification from relevant company confirming the interruption of services and whether any refund is applicable or been made, **Missed Departure**  
 If as a result of a breakdown/accident we need a copy of the motorists' emergency service or Police report confirming the details, **Missed Departure**

### E. Loss, theft or damage to Baggage (including delayed baggage), Valuables, Money and Documents

Evidence of value and ownership in the form of receipts or other documentation including manuals, warranties, photographs and valuations.  
 In respect of all claims for stolen/lost items, two (2) replacement quotes for item or equivalent model,  
 In respect of all claims for damage, letter from a repairer confirming cause and extent of damage sustained  
 A written report to confirm notification of damage/loss and non-recovery from

Airline/Hotel/Courier/Ships Purser or other applicable authority  
 Passenger Ticket and Baggage Recovery Tags,  
 In respect of all claims for stolen goods, a Police Report,  
 Documentation in support of money claimed. If foreign currency lost, Foreign Exchange receipts. If AUD lost, ATM withdrawal slips/bank statements. If paid in cash, confirmation from Employer,  
 Receipts regarding the replacement of any Document i.e. Passport, Airline Tickets etc.

### Misdirected or misplaced baggage

Travel itinerary detailing all stages (departure and arrival times of your Trip  
 Property Irregularity Report from Baggage Handling Administration / Documentation from the appropriate handler confirming total time baggage was delayed and reason for delay,  
 Receipts for ALL emergency purchases made

### F. Costs incurred due to Catastrophe

Airline tickets/Prepaid tickets,  
 Booking Conditions of flights/trip,  
 Letter from Airline/Tour Operator confirming amount of refund, if any,  
 Receipts/Bank Statements or other documentation showing the purchase of **pre-booked** accommodation,  
 Directive in writing from local or national authority deeming that you are forced to move from you pre-booked accommodation  
 Receipts/Bank Statements or other documentation detailing any **extra expenses** incurred.

### G. Collision Damage Waiver Excess (Damage to Rental Vehicle)

Hire/Rental Vehicle documentation evidencing details/conditions of hire/rental,  
 Documentation/receipts evidencing all amounts paid in respect of hire/rental vehicle (including insurance component and applicable Excess/damages),  
 Police report (if applicable)

### H. Additional Expenses incurred or any other incident not outlined above

Airline Tickets/Prepaid tickets,  
 Booking conditions of flights/trip/accommodation  
 Letter from Airline/Tour Operator/Travel Agent detailing amount of refund, if any  
 Receipts/Bank Statements or other documentation showing the purchase of **Pre-booked** accommodation,  
 Receipts/Bank Statements or other documentation detailing any **extra expenses** incurred

### Remember your...

Copy of your Travel Insurance Schedule, issued when you purchased your Insurance Policy,  
 Original Travel Itinerary and Tickets/Boarding Passes,  
 Any other documentation that you deem appropriate to support your claim

**MEDICAL CERTIFICATE.** This Medical Certificate must be completed by the ill/injured/deceased person's usual Doctor (General Practitioner), and **not** any Specialist Doctor he/she may attend. The Medical Attendant is respectfully requested to give as much detail as possible in order to assist the claimant and avoid the necessity of additional enquiries. (The Claimant must obtain this document at his/her own expense).

1	Name of person to whom this Certificate applies.	<input type="text"/>	
2	Date of Birth.	<input type="text"/>	
3	Are you his/her regular medical attendant?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If Yes, for how long?	<input type="text"/>	
	If No, please indicate in what capacity you attended the patient and for how long.		
	<input type="text"/>		
4	Please state:		
	a) Precise nature of illness/injury/death.	<input type="text"/>	
	If claim relates to injury please state how this was sustained.		
	<input type="text"/>		
	b) Date of onset of illness/injury.	<input type="text"/>	
	c) Details of patient's state of health and medical condition on the date the insurance was effected.		
	<input type="text"/>		
	d) Bearing in mind your response to c), was it reasonable for the claimant to continue with the travel plans?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	e) Date when there was deterioration, if applicable.	<input type="text"/>	
	f) Date when it first became apparent the claimant would be unable to travel.	<input type="text"/>	
	g) When did you advise claimant of need to cancel OR postpone?	<input type="text"/>	
	h) Has the patient previously suffered or received treatment, advice or medication for the same or any related condition?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If Yes, please provide the details, including the dates.		
	<input type="text"/>		
5	Was patient wait-listed for hospital admission?	Yes <input type="checkbox"/>	No <input type="checkbox"/>
	If Yes, please state:	Date wait-listed.	Date of admission.
		<input type="text"/>	<input type="text"/>
6	If pregnancy state E.D.D. and reason for cancellation advice.		
	<input type="text"/>		
7	Are you prepared to certify that solely due to the condition described above the Claimant is compelled to cancel OR postpone the holiday/travel.	Yes <input type="checkbox"/>	No <input type="checkbox"/>

I, <input type="text"/>	(Medical Practitioner) certify that the foregoing		
statements are correct.			
Signature:	<input type="text"/>	Date:	<input type="text"/>
Address:	<input type="text"/>		
Qualifications:	<input type="text"/>		