CLAIM FORM ➲

ETU Travel Insurance

EXTF221

If you need to speak with an advisor, please contact us on 1800 994 694

TO HELP US TO PROCESS YOUR CLAIM QUICKLY, PLEASE FOLLOW THESE GUIDELINES:

1. In the event of a medical emergency whilst still abroad, you must contact the Assistance Company as soon as possible. You can do so via: InternationalHealthcare@healix.com or +61 (0) 2 5133 7070.

2. If you are submitting a claim for medical and additional expenses, please complete sections A and B

3. Companions included on policy can be included in this claim form if applicable.

4. Costs incurred for the provision of any documentation/information required in the assessment of the claim are the responsibility of the claimant.

5. Failure or refusal to provide or make available evidence we require to complete the assessment of your claim may result in non-payment.

6. Send, or fax, or scan and email, or deliver your completed form in person to:

   Post: ATC Insurance Solutions Pty Ltd
   Level 4, 451 Little Bourke Street, Melbourne Vic 3000
   Fax: (03) 9867 5540
   Email: claims@atcis.com.au

SECTION A ➲ General information

(All questions in this section must be answered)

Required Documentation:

◯ Proof of your travel dates (e.g eTickets)

1. Your information

Title_____ First name_____ Last name _____

Address _____

Suburb_____ State_____ Postcode_____

Date of birth ____/____/_____ Occupation_____

Union Member number_____ Commencement of membership ____/____/_____

Unsure? Contact your union to obtain these details

◯ If I have provided any credit card statements as part of this claim submission, any personal information and/or full versions of my credit card number have been edited, redacted or removed.

Did you use a credit card to purchase your travel (eg. flights, accommodation, tours)? Yes ◯ No ◯

If yes, please complete the following

Name on Credit Card_____ Name of Financial Institution_____

Card Type Visa ◯ MasterCard ◯ Diners ◯ Amex ◯

Card Level Gold ◯ Platinum ◯ Other ◯

Total cost of all travel arrangements $_____ Cost of air fairs only $_____

Amount charged on credit card $_____

2. Payment

If your claim is approved we will deposit your settlement into your nominated bank account below (we cannot make payments to a credit card). We prefer to pay successful claims directly into your bank account as it is faster and safer.

Name of bank_____ Account holder name_____

BSB number_____ Account number_____

Please ensure that the bank account details you provide to us are correct. We will not be liable for any loss that you suffer as a result of payment(s) made to an incorrect bank account because the details you have supplied were incorrect. If you are unsure of your bank account details, please contact your bank or financial institution for assistance.

3. Claim Details

Date of incident ____/____/_____ Time_____ ◯ am / ◯ pm

Country_____ Town_____

Whereabouts/location _____

Please provide an explanation of your claim and why you are claiming (Please include a letter if more space is required).

_____

SECTION A ➲ General information continued

If the claim was caused by a health condition/dental problem/death please answer the following questions

Person whose state of health/dental problems/death caused the claim

Given name(s)_____ Surname _____

Relationship of that person to you _____

Has the illness/injury occurred before? Yes ◯ No ◯

If Yes, advise the condition

_____

Were you/was the person treated as a hospital inpatient overseas? Yes ◯ No ◯

Date admitted ____/____/_____ Time admitted _____ ◯ am / ◯ pm

Date discharged ____/____/_____ Time discharged _____ ◯ am / ◯ pm

Did you/the person contact the 24 hour emergency assistance team? Yes ◯ No ◯

SECTION B ➲ Trip Cancellation, Amendment or Additional Expenses

Required Documentation

- ◯ Booking confirmations showing breakdown of all trip costs
- ◯ Documents confirming refunds provided by the travel agency, tour company, airline etc
- ◯ Proof of payment of expenses paid by you (e.g receipts, credit card/bank statements showing payments made)
- ◯ Completed Medical or Death Certificate (where claim was due to medical reasons)
- ◯ Evidence of circumstances which impacted your trip (e.g Letter from transport provider explaining the circumstances of the cancellation/refund/compensation, letter from employer
- ◯ Airline tickets (including cost and points used)

Additional Documentation - Loss of Reward Points

- ◯ Reward statement showing total points used, any points charged as cancellation & any refund of points

Additional Documents - Additional or Other Expenses

- ◯ Evidence from the provider (Airline, Hotel, Bus company) explaining the circumstances of the expenses

Additional Documents - Resumption of Trip

- ◯ Revised booking confirmation, itinerary and invoice showing original and new booking
- ◯ Copy of return ticket used and unused
- ◯ Cancellation fees that would have applied had the original trip been cancelled in full

Details of Cancellation or Change

1. Was the cancellation/change due to illness, injury or death? Yes ◯ No ◯

   If no, Please advise reason

_____

2. If cancellation/change was caused by a person please provide the following

   Name of person causing the trip to be cancelled _____

   Relationship to you _____

3. Names of all people whose arrangements have been cancelled/affected

   _____

4. On what date did you cancel/amend your journey? _____/_____/_____

5. Can you travel on different dates? Yes ◯ No ◯

   If no, please explain reason why you have not amended the journey

   _____

Details of expenses claimed

DESCRIPTION OF COST	PROVIDER	AMOUNT PAID	AMOUNT REFUNDED (If applicable)	AMOUNT CLAIMED
1.		$	$	$
2.		$	$	$
3.		$	$	$
4.		$	$	$

If your trip was changed or postponed:

6. Total cancellation fee if trip was cancelled outright $_____

7. Additional amount paid $_____

8. Date trip was rebooked _____/_____/_____

If you lost Reward Points

9. Total amount of points used to purchase air ticket _____

10. Did you pay any additional amount towards this air ticket? Yes ◯ No ◯ $_____

11. Total amount of points refunded_____

12. Total amount of points lost_____

SECTION C ➲ Overseas Medical & Dental

Required Documents – Medical & Dental Expenses

- ◯ General Practitioner/Dentist Medical Certificate Original medical/dental receipts
- ◯ Treating doctors report
- ◯ Hospital admission and discharge reports where relevant
- ◯ Letter from dentist with details of emergency treatment provided

Required Documents – Loss of Income (Due to Injury)

- ◯ Doctors report detailing period unfit to work
- ◯ Pay summary from your employer for the 12 months prior to the departure of your trip (to allow us to calculate your average income)

1. Name of ill/injured person_____
2. Their date of birth _____/_____/_____
3. Relationship to you (if not you)_____
4. Nature of illness/injury_____
5. Date first occurred _____/_____/_____
6. Name and address of Doctor/Dentist who treated illness/injury

   _____
7. Place where Illness/Injury was treated_____
8. Were they admitted to hospital? Yes ◯ No ◯
9. Date admitted _____/_____/_____ Time admitted _____ ◯ am / ◯ pm
10. Date discharged _____/_____/_____ Time discharged _____ ◯ am / ◯ pm
11. Are you claiming for loss of income due to illness or injury? Yes ◯ No ◯

    If yes, go to question 12
12. Date due to return to work _____/_____/_____ Time due to returned to work _____ ◯ am / ◯ pm

SECTION D ➲ Luggage, Personal Property or Money

Required Documentation

- ◯ Proof of ownership of all items
- ◯ Repair quotes for damaged items
- ◯ Copy of notification to relevant authority made once loss, theft, damage or delay noticed (e,g. Carrier property irregularity report (PIR), Police Report, etc.)
- ◯ Original receipts for replacement items
- ◯ Boarding pass & baggage tags from the carrier, ATM, bank, credit card statement or currency conversion slips showing withdrawal of funds

Additional Documents – Replacement of Travel Documents

- ◯ Receipts or invoice of original travel documents
- ◯ Receipts relating to the replacement of travel documents

Additional Documents – Delayed Luggage

- ◯ Proof of purchase for essential items

SECTION D ➲ Luggage, Personal Property or Money continued

Your luggage includes your clothing and other personal belongings, including travel documents and things you buy during your trip.
Please note: as per your Product Disclosure Statement, some items may be subject to depreciation.

1. Are you claiming for: Loss ◯ Theft ◯ Damage ◯ Delayed ◯
2. Date and time Loss/Theft/Damage/Delay was discovered

   Date ____/____/_____ Time admitted _____ ◯ am / ◯ pm
3. Who was it reported to? Police ◯ Airline/Carrier ◯ Tour Guide ◯ Hotel Management ◯ Other ◯ Not Reported ◯

   If other please give details below

   _____
4. Name of police officer or relevant authority _____
5. Job title/position_____
6. Location_____
7. Report number _____
8. Date reported ____/____/_____ Time reported_____ ◯ am / ◯ pm
9. If not reported, please explain why

   _____
10. Have you claimed against your household insurance policy/private health fund for any of the items? Yes ◯ No ◯

If yes, Please give details: Name of insurer/fund_____

Policy/Member number_____ Amount paid by insurer/fund $_____

If your Luggage and Personal Effects were delayed

11. Date arrived at destination ____/____/_____ Time arrived at destination_____ ◯ am / ◯ pm
12. Date luggage arrived ____/____/_____ Time luggage arrived _____ ◯ am / ◯ pm
13. Have you made a claim against your carrier? Yes ◯ No ◯

    If yes, what compensation did the carrier pay you? Amount $_____ Currency _____

Please note: if your luggage is delayed, lost or damaged while in the care of the carrier, they may have a responsibility to compensate you. It is therefore essential that you first claim compensation from the carrier and obtain and provide us with written confirmation of their response to your claim.

Details of expenses claimed

FULL DESCRIPTION OF EACH ITEM	BRAND, MODEL, NUMBER ETC	MONTH & YEAR OF PURCHASE	PLACE OF PURCHASE	PROOF OF OWNERSHIP ATTACHED?	HAVE YOU REPLACED THIS ITEM?	ORIGINAL PURCHASE PRICE AND CURRENCY OR REPAIR QUOTE
		____/_____		◯	◯	$
		____/_____		◯	◯	$
		____/_____		◯	◯	$
		____/_____		◯	◯	$
		____/_____		◯	◯	$
		____/_____		◯	◯	$
		____/_____		◯	◯	$

SECTION E ➲ Rental Car Insurance Excess

Required Documentation

- ◯ The Rental Agreement/contract showing the excess you were liable to pay in the event of damage or theft.
- ◯ A copy of the itemised repair invoice showing the cost of repairs to the vehicle.
- ◯ A copy of the documents showing the amount debited by the rental car company for the damages/excess.
- ◯ The report made to the police or other relevant authority.
- ◯ If another party was at fault, written confirmation from them of the compensation payable by them/their insurer.

Date of incident _____/_____/_____ Time _____ ◯ am / ◯ pm

Country_____ Location_____

How did the accident/damage/theft occur?

_____

Excess you were liable to pay $_____ Repair costs $_____ Amount you are claiming $_____

Name of vehicle hire company_____

Name of person driving the vehicle _____ Their date of birth _____/_____/_____

SECTION F ➲ Other Expenses Claimed

This section is for any other expenses not mentioned above

NATURE OF EXPENSE	AMOUNT CLAIMED
1.	$
2.	$
3.	$
4.	$
5.	$
6.	$

Please forward relevant supporting documentation to assist us in processing your claim. For more information, contact Customer Service on 1800 994 694

Medical Form

If you need to speak with an advisor, please contact us on 1800 994 694

SECTION 1 ➲ Medical Authority

(To be completed by the person who was ill/injured)

Required Documents

- ◯ General Practitioner/Dentist Medical Certificate
  Original medical/dental receipts
- ◯ Treating doctors report
- ◯ Hospital admission and discharge reports where relevant
- ◯ Letter from dentist with details of emergency treatment provided

Required Documents – Loss of Income (Due to Injury)

- ◯ Doctors report detailing period unfit to work
- ◯ Pay summary from your employer for the 12 months prior to the departure of your trip (to allow us to calculate your average income)

To be completed by the person whose state of health caused the claim (or their Parent/Guardian, Executor of the Estate or Power of Attorney if applicable). Details of the patient's usual doctor or dentist (of at least 12 months prior to the policy issue date).

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for medical or dental conditions, injuries, or death which resulted in this claim. I acknowledge that a photocopy/scanned copy of this authorisation shall be considered as valid as the original.

Signature of patient/Executor/Power of Attorney Signatories name _____

Signatures Name_____ Date ____/____/_____

Medical Practictioner's email or postal address (include postcode)

_____

SECTION 2 ➲ Medical Certificate

(To be completed by the patient's usual Medical Practictioner in Australia)

To be obtained at the claimant's own expense from the patient's usual medical practitioner (whom they have attended in the 12 months prior to the issue date of the policy). Required for all medical claims or claims for cancellation or additional expenses arising from a person's health/medical condition.

Please Include All Patient Discharge Summaries

1. Name of patient_____ 2. Date of birth ____/____/_____
3. Are you the patient's usual General Practitioner Yes ◯ No ◯
   a. If Yes, for how long? _____
   b. If No, do you have access to their medical or dental records? Yes ◯ No ◯
   From what date? ____/____/_____
4. Please give a precise diagnosis and/or symptoms under investigation that has given rise to the claim. If an injury, how was it sustained?

   _____
5. Please state the date of the onset of the illness, or the date on which the injuries were sustained ____/____/_____
6. On what date was the condition first diagnosed? ____/____/_____
7. On what date did the patient first consult you in relation to this condition or symptoms of this condition? ____/____/_____

8. Have you or anyone else known to you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in the answer to question 4? Yes ◯ No ◯

9. In the 9 months prior to the departure date (or intended departure date), was the patient required to have regular check-ups, was undergoing or awaiting any diagnostic tests, test results, or medical investigations, or had been prescribed medication, undergone surgery or any procedure, or received therapy or rehabilitation? Yes ◯ No ◯

10. Was the patient advised not to undertake travel, as a result of any illness/injury? Yes ◯ No ◯

If yes, please provide details including date of advice

_____

11. Date the patient was advised that they would not be able to travel _____/_____/_____

12. Was it medically necessary for the traveller to amend or cancel their journey? Yes ◯ No ◯

If yes, plese provide details _____

SECTION 3 ➲ Declaration

Privacy Act

In this statement "we", "us" and "our" means Lloyd's and ATC Insurance Solutions (ATC) as its agent.

We are bound by the requirements of the *Privacy Act 1988* (Cth), the Privacy Amendment *(Private Sector) Act 2000* (Cth) and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. This sets out standards on the collection, use, disclosure and handling of personal information.

Our Privacy Policy is available at www.atcis.com.au or by calling us on the number below.

We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties (and/or collect additional personal information about you from them) who assist us in providing the above services and some of these are likely to be overseas recipients in the United Kingdom. These parties which include our related entities, distributors, agents, insurers, claims investigators, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Medicare Australia and Centrelink will only use the personal information for the purposes we provided it to them for (unless otherwise required by law).

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information and request correction if required. You may also opt out of receiving materials sent by us by contacting ATC on (03) 9258 1700 or write to us at the address given on page one.

Authority & Declaration

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to ATC or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Workers' Compensation claims, claims with any other insurer or any leave benefits and payments, to be released to ATC. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

I declare that my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.

Signature _____

Name (print) _____ Date _____/_____/_____