Ozicare INSURANCE

Travel Insurance Claim Form

Loss of Income

You must register any claim within 30 days of completion of your travel. Please supply original documents of the evidence you intend to rely on for your claim, and send by registered post to ensure delivery.

Claimant Details

Claim Reference (if known)

Title *(Mr / Mrs etc)*

First Name

Surname

Date of Birth / /

Nationality

Occupation

Medicare Number

Parent / Guardian's Medicare Number
(If medical claim is for a minor)

Home Address

Home Phone

Work Phone

Mobile

State

Postcode

Email

Policy Details

Policy Number

Date Issued / /

Number of Travellers

Independent Travel Arrangements: **Yes** ☐ **No** ☐ *If no, provide the following*:*

***Travel Agent and Branch**

***Tour Operator**

Date of Booking / /

Departure Date / /

Return Date / /

Total Days

Country

Resort / Town

I DECLARE THAT:

- I will use my best endeavours and render all reasonable assistance and co-operation to Auto & General Insurance Company Limited 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, Auto & General Insurance Company Limited has 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 Auto & General Insurance Company Limited 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 Auto & General Insurance Company Limited in its absolute discretion considers relevant for its 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 benefit, or my entitlement to receive an ongoing benefit.

Privacy Statement

The personal and sensitive information collected in this form, and other information you or third parties provide in connection with this claim will be held, used and disclosed by us to process this claim, compile and analyse data, and resolve claim disputes.

We may have to disclose your personal and other information to third parties who assist us in assessing and processing this claim, including other insurers, health providers, investigators, our specialist advisors, service providers, or as required by law. Your personal information may also be disclosed to third parties in the countries and regions nominated under your policy, or any other regions where you may require assistance. For further information please see our privacy policy or email us at autogeneral@claims-travel.com.au.

If you wish to give authority for another person to act on your behalf in respect to this claim you must complete the following details (otherwise we will not be able to give any information about your claim to any other person).

I / We, authorise (Name)

of (Address)

Postcode

Phone

Mobile

Date of Birth / /

I have read and fully understand the declarations above (ALL persons claiming must sign)

Claimant's Name	Signature	Date of Birth	Date
		/ /	/ /
		/ /	/ /

Claimant's Name	Signature	Date of Birth	Date
		/ /	/ /
		/ /	/ /

Please return this claim form to:
Ozicare Travel Insurance, GPO Box 14, Brisbane QLD 4001

This **must be** completed by the injured person's employer, or if self employed, by an accountant. This form is to verify the loss of income of a person whose illness / injury / death has given rise to the claim. Any charge made for the completion of this form is the responsibility of the insured and is not refundable under the insurance policy. Please ensure the employer answers all relevant questions. Ticks, dashes, N/A etc will not be acceptable. This information will be treated as private and confidential.

Employee Details

Title *(Mr / Mrs etc)* | **First Name** | **Surname** | **Date of Birth** (/ /)

Home Address

Home Phone

Work Phone

Mobile

State | **Postcode**

Email

Employment Details *(as at date of incident)*

If the injured person was self employed you do not have to complete this section. Go to 'Employer or Accountant details' below.

Place of employment | **Date employment commenced** (/ /) | **Date employment would have ceased** (/ /)

Description of duties

Employee's normal working hours *(include regular and continuing overtime)*

Days per week | **Hours per day** | **Usual start time** ☐ AM ☐ PM | **Usual finish time** ☐ AM ☐ PM

If the employee worked regular overtime, would it have continued if there had not been an accident? **Yes** ☐ **No** ☐ *if yes, please provide details:*

Employer or Accountant Details

If the injured person was self employed you need to complete this section.

Name / organisation / company name | **ABN/ACN**

Address

Phone

Email

What is the nature of the business

Is the employee related to the employer? **Yes** ☐ **No** ☐ *if yes, please provide details:*

Wage Details

What were the usual weekly earnings including overtime, regular bonuses, commission etc of the employee (paid on a regular basis) before the incident

Gross normal earnings | **Gross overtime earnings** | **Other gross earnings**

Total gross earnings | **Less tax** | **Total net earnings**

What award did the employee work under: **Federal** ☐ **State** ☐

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Details of Absences as a Result of The Accident

On what dates was the employee absent from work due to the accident

Work time lost (weeks / days / hours)	Date From	Date To
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

Has the employee returned to work: Yes ☐ No ☐ **If no, will the position be held open:** Yes ☐ No ☐

If payments have been made give details below *(eg sick pay, workers compensation)*

Details of payment / amount

Details of person completing this form *(Employer or Accountant)*

Name

Position in business

Home Phone

Mobile

Work Phone

Email

Signature

Date / /

Bank Details of Claimant

Should Auto & General Insurance Company Limited need to reimburse you we require your bank details.

Name of Account Holder

BSB

Account Number

GST *(for domestic policy claims only)*

Are you registered for GST and did you claim a GST input tax credit on your premium? Yes ☐ No ☐

If yes, what is your input tax credit entitlement percentage: *(i.e. a full entitlement is 100%)*

Additional space to continue any questions necessary

Medical Certificate

This **must be** completed by the **Registered General Practitioner** (GP) of the person whose illness / injury / death has given rise to the claim. Any charge made for the completion of this certificate is the responsibility of the insured and is not refundable under the insurance policy. Please ensure the GP answers all relevant questions. Ticks, dashes, N/A etc will not be acceptable. This information will be treated as private and confidential. A certificate not containing the specific information requested will not normally suffice.

Full name of patient **Date of Birth** / /

Are you the regular medical attendant / from the same practice: Yes ☐ No ☐ **If yes, for how long**

If no, what is your involvement with this matter

State precise nature of the medical condition / illness / injury / cause of death, that gives rise to this claim

If injury, state how this was caused

If claim is result of pregnancy: **Date pregnancy confirmed** / / **LMP** / / **EDC** / /

Has patient suffered from the same or related condition in the past five years: Yes ☐ No ☐ **If yes, for how long**

State the exact date of onset of symptoms of conditions / / **Date first consulted** / /

Date of any serious deterioration / exacerbation, if applicable / /

What ongoing medical condition(s), or medical complication directly attributable to the condition(s), were being investigated by a registered medical practitioner at:

Date trip insurance was purchased / / **Date trip was booked** / /

Is the illness / injury attributable to drugs, alcohol or HIV or HIV related illness, including AIDS: Yes ☐ No ☐

Give details

Has the person named above received a terminal prognosis: Yes ☐ No ☐

If yes, what date was the terminal prognosis given to: **The patient** / / **The claimant** / /
(if not the same person)

Has the patient been referred to or seen by a hospital doctor or surgeon or needed inpatient treatment for this or any related condition within 12 months prior to the date the trip insurance was purchased? If so, please give full details including dates:

If the patient was booked to travel did they consult you prior to booking or travelling regarding the advisability of undertaking the holiday or journey:

Yes ☐ No ☐ **If yes, on what date** / /

If no, when would you have advised cancellation had you been aware of the planned trip

If the patient travelled, were they fit to travel the date of departure

Provide details of patient's state of health at the time the insurance was purchased and date of booking the trip

State exact reason for cancellation

Please advise the date when it first became apparent that the holiday should be cancelled / /

Please state the exact date you advised the need to cancel / /

Are you prepared to certify that, soley due to the condition described above, the claimants are compelled to cancel their holiday arrangements:

Yes ☐ No ☐

To be completed by the usual Registered General Practitioner (GP): I have examined the patient and / or referred his / her medical records and I declare that the information given is correct and that no details relevant to the case have been omitted.

Name **Qualifications**

Sign **Date** / /

Surgery Stamp