Ozicare INSURANCE

Travel Insurance Claim Form

Medical Emergency and Associated Expenses

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
		/ /	/ /
		/ /	/ /

Medical Emergency and Associated Expenses

Injury Occurrence: **Date** / / **Time** ☐ AM ☐ PM

Country and town where illness or injury occurred

Full description of illness or injury and details of any third party involved

Have you previously suffered from the condition which has resulted in the submission of this claim, or any related condition:

Yes ☐ **No** ☐ *If yes, we may require your GP to complete a medical certificate*

If you were an inpatient: **Date of admittance** / / **Time** ☐ AM ☐ PM

Date of discharge / / **Time** ☐ AM ☐ PM

If you were an inpatient or an outpatient and expenses exceeded $500 did you contact medical emergency assistance:

Yes ☐ **No** ☐ *If yes, please complete the fields below. If no, please provide a written explanation as to why not (please use separate sheet at the end of the form).*

Date of first call / / **Person spoken to**

Reference No

Medical Emergency and Associated Expenses *(Please list all expenses and continue on separate sheet at the end of the form if necessary)*

Name of Doctor / Dentist / Pharmacy / Hospital or Provider	Treatment Performed	Date of Treatment	Amount Charged (State Currency)	Paid Yes / No	Refund from Health Funds
e.g. Doctor R Smith	e.g. Consultation	e.g. 10/02/07	e.g. EUR 100	e.g. Yes	e.g. EUR 75

Documents You Need to Send Us – **SEND ORIGINAL DOCUMENTS BUT KEEP COPIES FOR YOUR RECORDS**

1. Original evidence to show dates of outward and return travel (booking invoice, travel tickets, itinerary etc.)
2. All original invoices / receipts for expenses incurred.
3. If claim is submitted on behalf of the estate of a deceased insured, we will require certified copies of the death certificate, together with Grant of Probate or Letters of Administration. If the insured passed away due to illness rather than as a result of injury, we may require a medical certificate to be completed by the deceased's usual GP.
4. If this claim is being submitted as a result of injury please provide a full description of the incident leading to the injury. If a third party was involved please provide their details and those of their insurer if available.

If you are unable to supply any of the documentation requested please provide a written explanation as to why.
Important - Please number all receipts for expenses incurred or pre-loss supporting documentation and put the number in the column headed 'Receipt No.' when completing the 'Medical Expenses' section above.

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

Other Insurance

Do you (or anyone else claiming) have any other insurance which may cover this trip. eg Travel insurance with your bank / credit card account, tour operator / travel agent or home contents insurance etc. *(NB contribution payment is normal practice where 2 policies cover the same loss).*

Yes ☐ **No** ☐ *If yes, please supply the following details:*

Company name and address

Policy Number

Has a claim been submitted to any other company for this incident: **Yes** ☐ **No** ☐ *If yes, please provide details:*

Health Conditions

At the date of travel, purchase of the policy or booking your trip, were you or the person whose condition has given rise to the claim:

Aware of any medical condition or set of circumstances which could reasonably be expected to give rise to a claim	**Yes** ☐	**No** ☐
Have an on-going medical condition (or any medical complication directly attributable to that condition) which was being investigated by a specialist or GP *(if the condition was declared at purchase of the policy, please give details below)*	**Yes** ☐	**No** ☐
Have a medical condition directly or indirectly related to the condition for which the claim is being made *(if the condition was declared at purchase of the policy, please give details below)*	**Yes** ☐	**No** ☐
Received or were awaiting hospital tests or treatment for any condition or set of symptoms which had not been diagnosed	**Yes** ☐	**No** ☐
Had been given a terminal prognosis	**Yes** ☐	**No** ☐
Were travelling for the purpose of obtaining medical treatment abroad	**Yes** ☐	**No** ☐
Were travelling against the advice of a medical practitioner	**Yes** ☐	**No** ☐
Had received or were awaiting treatment relating to a complication of pregnancy or childbirth	**Yes** ☐	**No** ☐
Were more than 32 weeks pregnant at the start of or during your trip	**Yes** ☐	**No** ☐
Was a letter concerning any of the above obtained from the treating doctor *(if yes, please forward a copy of the letter)*	**Yes** ☐	**No** ☐

If yes was answered to any of the above, please give further details of the condition or circumstances
(Please note that we may need your GP to complete a medical certificate)

Are you expecting to receive or are you going to submit any further accounts: **Yes** ☐ **No** ☐ *If yes, please provide details*
(continue on separate sheet at the end of the form if necessary)

Important Notes:
If you require us to make a direct payment for medical costs, and your policy is subject to an excess, this must be paid before we can do so. Please enclose a cheque made out to Auto & General Insurance Company Limited or contact us to arrange payment by credit / debit card. If you have paid all costs, please enclose all receipts. Payment of acceptable expenses would normally be made to the claimant. If you require payment to be made to another person, please forward their details and provide your written permission for us to do so.

Bank Details

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

Name of Account Holder

BSB **Account Number**

GST

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