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Travel Insurance Claim Form | Cancellation/Trip Abandonment

Europe Assistance Australia
PO Box 547 | Pyrmont | NSW | 2000 |

PLEASE ANSWER ALL RELEVANT QUESTIONS ON THE CLAIM FORM; LEAVING ITEMS BLANK, USING TICKS, DASHES AND N/A MAY RESULT IN US RETURNING THE CLAIM FORM AND/OR ASKING FURTHER QUESTIONS, THUS DELAYING THE PROCESSING OF YOUR CLAIM.

Claimant Details

Claim Reference(if known):

Title: *(Mr/Mrs etc)* **Surname:** **Forename(s):** **Date of Birth:** / /

Nationality: **Occupation:**

Home Address:

Home Tel:

Work Tel:

State: **Postcode:** **Mobile:**

Email:

Policy Details

Policy Number: **Date Issued:** / / **No. in Party:**

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

*** Travel Agent & Branch:** *** Tour Operator:**

Date of Booking: / / **Departure Date:** / / **Return Date:** / / **Total Days:**

Country: **Resort/Town:**

It is against the law to submit a fraudulent insurance claim.
If your claim is found to be fraudulent the claim will be declined and Insurers will pursue recovery by the use of civil action.

1. I/We hereby declare that all information, answers, and documents given in connection with this claim are true and correct to the best of my/our knowledge and belief. I/We have not omitted any material information, which would affect the Underwriters judgment of the claim. I confirm that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf, and I confirm that I understand that neither Europ Assistance nor the underwriters will accept responsibility if any payments are not distributed proportionately to the persons concerned.
2. I/We understand that the information on this form will be passed to or used by Europ Assistance for my insurance, this includes underwriting, processing, handling claims and preventing fraud and could include passing details to agents or other Insurers.
3. I/We subrogate all rights of recovery to Europ Assistance and also consent to them seeking reimbursement of any medical expenses paid by them.
   For medical related claims:
4. I authorise any doctor, hospital or other organisation or person having any records or information concerning my medical history or treatment to furnish such records or information as may be requested by Europ Assistance or their agents. I understand that in executing this authorisation, I waive the right for such information/records to be privileged. I am also aware that such information/records are relevant in the evaluation of my claim and that non - submission could prejudice my claim. A photocopy of this authorisation shall be considered as effective and valid as the original.

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

Claimants Name	Signature	Date of Birth	Date
		/ /	/ /
Claimants Name	**Signature**	**Date of Birth**	**Date**
		/ /	/ /

Reason for cancellation – Please select one box only

Death ☐ Jury Service ☐ Injury ☐ Redundancy ☐ Illness ☐ Delay ☐

Damage/Theft to Home/Business ☐

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

1. The original trip cancellation invoice. If your booking was flight only you may not be able to obtain this document, if so, please obtain written confirmation from airline or travel agent.
2. Original booking invoice, showing date of booking, date of travel and a full breakdown of the trip costs. Please also supply all unused travel tickets, itineraries etc.
3. If cancellation is due to redundancy, we require a letter from your former employer which confirms you have been made redundant and are due to receive a payment under current Redundancy Payment Legislation, the position you held and your length of service.
4. If cancellation is on medical grounds, including death, the attached medical certificate must be completed by the usual medical practitioner of the individual whose condition has led to the submission of the claim.
5. If cancellation is due to a death, we also require a certified copy of the death certificate. In addition, if the deceased is an insured person under the policy, we require a copy of the Grant of Probate issued in respect of the deceased's estate.
6. If the claim is being submitted as a result of an 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.
7. If claim is for trip abandonment, we require written confirmation from the airline of the delay/cancellation of the flight, the reason for the delay and the length of time the delay lasted.
8. If cancellation is for any other reason, please provide independent written evidence of the incident or circumstances which have resulted in the submission of the claim.

When did you become aware of the need to cancel your holiday: **Date:** / / **Time:**

When did you inform the airline, accommodation provider, travel agent or tour operator of the need to cancel your holiday:

Date: / / **Time:**

If applicable, please give the name of the person who has caused the cancellation and their relationship:

Name: **Relationship:**

Details of holiday cost and cancellation charges

Ticket costs:	**$**
Accommodation costs:	**$**
Pre-booked excursions	**$**
Deduct refunds received or advised:	**$**
Total amount claimed:	**$**

Names and dates of birth of all those cancelling:

Name	DOB

Please detail the reasons for cancellation below, giving details of any third party involved (continue on a separate sheet at the end of the form if necessary)

Other Insurances

Do you (or anyone else claiming) have any other insurance which may cover this trip (e.g Travel insurance with your bank/credit card account, tour operator/ travel agent or home contents insurance etc.)
NB (A 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, pleaseprovide details:

Previous Claims

Have you made any previous claims on this type of insurance **Yes** ☐ **No** ☐
If yes, please provide details:

Method of payment: **Cash** ☐ **Cheque** ☐ **Credit/Debt Card** ☐ **Reward points/Airmiles** ☐

If a Credit/ Debt card was used to pay all or some of the trip cost, please state:

Name of card supplier	Card type

Bank Details

Should Europ Assistance need to reimburse you we require your bank details as follows:

Name of Account Holder

BSB **Account number**

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:

The 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:

If cancellation, 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

Separate sheet to continue any questions necessary