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Travel Insurance Claim Form | Medical Emergency and Associated Expenses

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:
Mobile:
Email:

State: | **Postcode:**

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**
		/ /	/ /

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 below

Medical Emergency and Associated Expenses

Injury Occurrence Date: / / **Time:**

Country and town where illness 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 mayrequire your GP to complete a medical certificate**

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

Date of discharge: / / **Time:**

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

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

Date of first call: / / **Person spoken to:** **Reference No:**

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

Receipt No.	Date	Description of item	Bill from	Amount	Currency	Exchange rate	Paid Y/N	Office use only
						Total Claimed		

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:

Previous Claims

Have you made any previous claims on this type of insurance **Yes** ☐ ☐
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: **Yes** ☐ **No** ☐
(if the condition was declared at purchase of the policy, please give details below)

Have a medical condition directly or indirectly related to the condition for which the claim is being made: **Yes** ☐ **No** ☐
(if the condition was declared at purchase of the policy, please give details below)

Received or were awaiting hospital tests or treatmentfor 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 amedical practitioner: **Yes** ☐ **No** ☐

Had received or were awaiting treatment relating to a complication of pregnancy or childbirth: **Yes** ☐ **No** ☐

Were you more than 32 weeks pregnant at the start of or during your trip: **Yes** ☐ **No** ☐

Was a letter concerningany of the above obtained from the treating doctor: **Yes** ☐ **No** ☐
(if yes, please forward a copy of the letter)

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 direct payment of the medical costs and your policy is subject to an excess, this must be paid before we can do so. Please enclose your remittance in favour of Europ Assistance or contact us to arrange payment by credit/debit card. If you have paid all costs, please enclose all receipts.
Payment of admissible expenses would normally be made in favour of the claimant. If you require payment to be made in favour of another person, please forward their details and provide your written permission for us to do so.

Bank Details

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

Name of Account Holder

BSB **Account number**

Separate sheet to continue any questions necessary