

SECTION FOUR: TRAVEL INFORMATION - COMPULSORY

Departure Date

Return Date

Departure City

Destination City

Departure Country

Destination Country

Reason For Travel

Business / Work

Holiday

Combination

Other

SECTION FIVE: DETAILS OF INCIDENT - COMPULSORY

Date of Incident

Time

AM / PM

Incident City

Incident Country

Please describe how the accident / damage / theft / loss / illness occurred and complete relevant sections :

SECTION SIX: MEDICAL EXPENSES - (IF APPLICABLE)

- **This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.**
- Medical Receipts will be required to accompany this section.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the curtailment of the journey.
- All medical and hospital accounts incurred within Australia must first be submitted to Medicare for refund, also to your private health fund if applicable.

Was the Emergency Assistance Company contacted? Yes No

If an Illness, has the claimant suffered this complaint before? Yes No

If Yes, please provide details:

Date of Expense	Medical and/or Hospital Expenses <i>(use separate sheet if insufficient space)</i>	Amount Claimed (Please state currency)

SECTION NINE: ADDITIONAL AND/OR FORFEITED EXPENSES - (IF APPLICABLE)

- This section is to be completed **ONLY** where the event has occurred **AFTER THE COMMENCEMENT** of the Insured Travel.
- Only original accounts or receipts for, accommodation and transport costs will be accepted.
- For additional expenses, a **MEDICAL CERTIFICATE**, or the Medical Certificate on Page 6 of this form, from the doctor who treated you must be provided to support change of plans due to accident, illness or death.

If you are claiming for additional expenses, what were your original plans for accommodation/transport and how were they changed?
 Please ensure copies of original and amended itineraries are provided.

Date of Expense	Additional Transport / Accommodation Expenses <i>(Please Supply Full Details)</i>	Amount Claimed <i>(Please state currency)</i>

Date of Expense	Forfeited Expenses <i>(Please Supply Full Details)</i>	Amount Claimed <i>(Please state currency)</i>

SECTION TEN: HIRE CAR EXCESS EXPENSES - (IF APPLICABLE)

Please ensure a copy of your Hire Vehicle Agreement, Damage Report and repair invoice(s) are attached.

Type of Vehicle Name of Vehicle Hire Company

Car Other

Title Driver's Full Name

Rental Vehicle Excess Currency Actual Repair Costs Currency Amount you are claiming Currency

\$
 \$
 \$

SECTION ELEVEN: CANCELLATION / LOSS OF DEPOSITS - (IF APPLICABLE)

- If you are claiming because you cancelled your trip PRIOR to departure, as a result of injury, illness or death, you MUST have the Medical Certificate on Page 6 completed by the regular doctor of the person whose state of health has resulted in the claim.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the cancellation of the journey.
- A supporting document from the travel provider showing cancellation charges must be submitted with this form.

Date travel arrangements booked:

Date of Cancellation:

Reason for Cancellation:

If cancellation is due to accident, illness or death state the name of the person whose accident, illness or death necessitates the cancellation of the travel.
IN THE EVENT OF DEATH, PLEASE ATTACH DEATH CERTIFICATE

Title Given Name(s)

Family Name Relationship of person to claimant:

Amount Paid	Currency	Amount Refunded	Currency	Amount Claiming	Currency
\$ <input style="width: 100px;" type="text"/>	<input style="width: 30px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	<input style="width: 30px;" type="text"/>	\$ <input style="width: 100px;" type="text"/>	<input style="width: 30px;" type="text"/>

If no refund amount is noted please state why (you must obtain all refund possible)

SECTION TWELVE: DECLARATION - COMPULSORY

Dispute Resolution Statement
 Accident & Health International Underwriting Pty Ltd is an agent for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.
 If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within fifteen (15) working days. If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme.
 Access to the Dispute Resolution scheme is free of charge to you.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:
 I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We agree that, by submitting this form, the personal information I/We provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in our [Privacy Policy](#) including for the processing of this claim.

Authority
 I authorise any hospital and/or physician who has treated me to provide Accident & Health International with copies of medical records or of my past medical history, as requested.

Signature of Claimant

Date

Signature of the Insured (if other than claimant)

Date



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ACCIDENT & HEALTH INTERNATIONAL MEDICAL CERTIFICATE

THE CLAIMANT MUST OBTAIN AT OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES OF CANCELLATION AND MEDICAL CLAIMS RESULTING FROM ACCIDENT, ILLNESS OR DEATH.

IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRES

SECTION THIRTEEN: PATIENT DETAILS

Title Given Name(s)

Family Name Date of Birth

1. Are you his/her usual medical attendant? Yes No

2. If Yes, for How long?
 Days Months Years

3. Please give precise details of the nature of the illness or injury.

4. Start date of onset of illness, or date

5. State date on which you were first consulted in relation to the condition described above and, in your opinion, how long the condition has been present prior to consultation.

First Consultation Date Condition has been present prior to consultation for:

6. Are you prepared to certify that solely due to the condition described in question 4, the claimant/s was/were compelled to cancel the travel arrangements? Yes No

7. What treatment, if any, has your patient previously received for this or any other related condition, and when was treatment received?

8. Is he/she suffering from any chronic disease or illness or from any physical defect or infirmity?

9. If the claim is as a result of a death, in your opinion, was it sudden and unexpected? Please give reasons for your answer.

Print Name: <input type="text"/>	Qualification: <input type="text"/>	Signature of Doctor <input type="text"/>
Address: <input type="text"/>	Phone: <input type="text"/>	Date <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
	Fax: <input type="text"/>	