Travel Insurance Claim Form

What You Need To Do

Before making a claim, it is important to have the following information available:

1. Your travel insurance policy number (from your Certificate of Insurance)
2. Your daytime contact details and trip details
3. A copy of your itinerary, electronic tickets and/or travel booking confirmations
4. Particulars of your claim and any supporting documentation.
   For example: copy of any medical, police or airline reports, the contact details of any treating doctor or hospital you attend, photos of any damage or loss, and any original receipts for payments made.

   Note: Original documentation will be required in order to finalise your claim. Please keep a copy of all documents for your records.

Please follow the instructions on the claim form, including requests for documentation to support your claim.

The declaration on the final page must be signed and dated.

Please send the completed form and all supporting documentation to:

Travel Claims
QBE Insurance
PO Box 44, Auckland 1140
Email: travelclaimsnz@qbe.co.nz
Fax: 0800 800 408 | +64 9 307 0035

Insurance policy number

Please attach a copy of your Certificate of Insurance to this claim.

Please indicate claim type ◯ **International travel claim** ◯ **Domestic travel only**

Client Details

Insured name | **Title** | **Date of birth**

Address

Daytime phone number | **Other phone number**

Email

Occupation

Name of agent who arranged travel

Name of agent who arranged insurance

Were you travelling for ◯ **Holiday** ◯ **Visiting Friends/Relatives** ◯ **Business** ◯ **Event**

This section must be completed for all claims

Please provide a full description of the events leading to your claim

Continue on another sheet if necessary

Date and time the 1st loss or incident happened

Country/Town/ Location (e.g. Hotel Reception)

Did you contact our emergency assistance team – QBE Assist? ◯ Yes ◯ No **If Yes, date**

Have you ever made any other insurance claims (except motor vehicle)? ◯ Yes ◯ No

If Yes, please give date, name of company, type and amount of claim

Have you any other insurance which may cover this claim? ◯ Yes ◯ No

If Yes, with whom?

Did you use a credit card to purchase your travel? (e.g. flights, accommodation, tours) ◯ Yes ◯ No

Card ◯ Visa ◯ MasterCard ◯ American Express

Card type: ◯ Gold ◯ Platinum ◯ Other

Baggage Claim

For all claims in respect of baggage lost, damaged or delayed by a carrier, we will require a full copy of the claim you have submitted to them along with their response and settlement breakdown.

Date of incident **Time** ◯ am ◯ pm

Date discovered **Time** ◯ am ◯ pm

Place where loss, theft or damage occurred

To whom was the incident reported? ◯ Police ◯ Carrier ◯ Other **Date** **Time**

You must attach the original reports given to you. If you do not have a report please advise why.

Details Of Loss Of Baggage

Proof of value and ownership in the form of purchase receipts, valuation certificates (and credit card statements if applicable) obtained prior to the loss, MUST be included.

Description of property lost, destroyed or damaged	Date of purchase	Original price paid	From whom purchased	Has this item been replaced
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
Continue on a separate sheet if necessary	**Total $**			

Cancellation Charges

You must provide documentation from the tour operator, carrier and travel agent verifying the cancellation charges imposed by them.

Name of person causing cancellation		**Date of birth**	
Relationship to person cancelling			
Reason for cancelling (death, illness etc)			
Date of incident		**Date holiday/ journey cancelled**	
Names of all who are cancelling			
Total cost of holiday (excluding insurance)			
Total amount refunded by tour operator/carrier			
Total amount of claim			

The medical certificate on page 6 of this form must be completed in cases of cancellation arising from death, illness or injury. In the event of a death a copy of the death certificate will be required. You must include independent evidence to support your claim if from any other insured cause.

Additional Expenses

Please attach receipts for all additional expenditure incurred.
Medical certificate: If additional expenses were incurred because of medical reasons the medical certificate on page 6 must be completed by the usual doctor (GP) of the person whose state of health/injury caused you to incur the additional expenses.

Relationship to you of the person whose state of health caused you to incur the additional expenses

List of expenditure for which reimbursement is required	Amount claimed

Medical Expenses

Name of ill/ injured person | **Date of birth**

Relationship to insured

Nature of illness/injury

Has the ill/injured person suffered from the same or similar illness/injury before? ◯ Yes ◯ No

If Yes, please give details including dates

Was a doctor consulted at the time of booking the holiday? ◯ Yes ◯ No

Did he/she consider the ill/injured person fit to travel? ◯ Yes ◯ No

Name and address of ill/injured person's usual doctor

Name and address of doctor who treated illness/injury

If admitted to hospital

Date admitted | **Time** | ◯ am ◯ pm

Date discharged | **Time** | ◯ am ◯ pm

Date of expenses	Name of Dr, clinic or other authority who issued receipts/invoices	Cost incurred (state currency)	Paid by yourself
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No
			◯ Yes ◯ No

(Continue on a separate sheet if necessary)

Except in the case of minor illness or injury the medical certificate on page 6 will be required. We must ask you to note that where this is not completed we reserve the right to require its completion at a later date. In the event of death a copy of the death certificate will be required. If the claim is for repatriation or curtailment of your journey you should include the medical certificate issued by the treating doctor confirming the necessity of this.

What else are you claiming for?

Description

Claimants Declaration

Declaration

I do solemnly and sincerely declare that the particulars contained in this form are true and correct in every detail and I agree that if I have made, or in any further declaration in respect of the above said claim shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Furthermore

In consideration of QBE Insurance agreeing to meet payment of this claim I/we hereby agree to discharge QBE Insurance from any further liability, claims or demands in respect of this claim. Any property which is the subject of this claim will be owned by QBE Insurance by virtue of the claim having been settled in respect of such property.

Privacy Act

I acknowledge that QBE Insurance require this personal information from me before it will decide whether to accept this claim. This information will be retained and held by QBE Insurance. I understand that the Privacy Act entitles me to have access to and require correction of this information. I authorise QBE Insurance to disclose this information to its advisers, other insurers, to reinsurers and other parties. I further authorise QBE Insurance to obtain information about me held by any other party that is in its view relevant to this claim.

Medical Authority

I hereby authorise any hospital, physician or other person who has attended me to furnish to QBE Insurance or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and all copies of hospital or medical records. I agree that a scanned/imaged copy of this authorisation shall be considered as effective as the original.

Signature **Date**

Payment Details

If your claim is approved we can deposit your settlement directly into your bank account. Otherwise we will send you a cheque in the name of the Insured.
Please provide your details below:

Name of Bank **Branch**

Account Holder Name

Account Number

Please check that the bank account details are correct. We will not be liable for any loss that you suffer as a result of payment(s) made to an incorrect bank account because the details you supplied on this form were incorrect.

Medical Certificate

To be completed by the usual doctor (GP) of the person whose state of health/injury has caused you to make this claim.

Name of patient		**Date of birth**	
Are you his/her usual GP?		**For how long**	
Please provide precise diagnosis of the illness/injury			
Date of onset of illness/injury		**Date on which you were first consulted**	**Date referred to a specialist**
Name and address of specialist/surgeon			

Is the described condition caused, accelerated or traceable to any recurring illness or condition? ◯ Yes ◯ No ◯ Unknown

If Yes, please confirm dates of consultations regarding the condition and prescriptions given over the past 6 months	
Please give details of any chronic disease or illness or physical defect or infirmity from which he/she suffers	

How long was or will the patient be prevented from travelling? **From** **To**

Had patient planned to travel against your prior advice?	

Was the patient confined to bed, home or hospital for 3 days or more in the 30 days prior to the purchase of travel insurance? ◯ Yes ◯ No

Details	

Did the patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment? ◯ Yes ◯ No

Name of Doctor			
Address			
Signature		**Date**	