

Travel Claim

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A. NOTES

1. It is most important that all questions are answered. If not applicable, write "n/a".
2. The issue of this claim form is not an admission of liability by QBE.
3. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
4. Any amounts further marked as * are in the currency of the country in which the policy has been issued.
5. Markets

Please use the checklist below to indicate the operation in the QBE Pacific Islands region to which you will be submitting your claim.

Market	Business Name	Please tick
Fiji	QBE Insurance (Fiji) Limited	
Papua New Guinea	QBE Insurance (PNG) Limited	
Solomon Islands	QBE Insurance (International) Limited	
Vanuatu	QBE Insurance (Vanuatu) Limited	

Note: For any other markets please contact the local QBE office.

6. The content and use of this form or any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by:
 - a) the laws of the country at the QBE office which issues the policy/ies upon which this present claim is made; unless
 - b) the policy/ies refer to the laws of a different country applying, in which case, the laws of that country,
 and in relation to those matters, the parties submit to the jurisdiction of the courts of that country.

For those policies governed by the laws of the Republic of Vanuatu, the validity, interpretation and effect and the rights and obligations of the parties to such policies shall be governed exclusively by English Law as applicable within Vanuatu immediately before 30 July 1980 and shall be justiciable before the Supreme Court of Vanuatu.

COMPULSORY COMPLETION FOR ALL CLAIMS

B. INSURED DETAILS

1. Name of insured:
2. Address:
 Postcode:
3. Private tel no: Business tel no:
 Mobile tel no: Fax no:
 Email:
4. Occupation:
5. Certificate number: Please attach your certificate
6. Travel agent: Telephone: ()
7. Date of booking travel arrangements: ___/___/___
8. Date of departure: ___/___/___ Date of return: ___/___/___

9. Have you made previous claims for travel insurance? YES NO

If "YES", please give details

Name of insurer	Date of claim

ONLY COMPLETE RELEVANT SECTIONS PERTAINING TO YOUR CLAIM

C. CANCELLATION CLAIMS DETAILS

1. The following documents are required in support of your claim. Please tick (✓) when attached
 - Doctor's certificate (see Section H)
 - Travel agent's letter confirming details of tour costings and cancellation charges
 - Transport provider's reports
2. Reason for cancellation:
3. Date of cancellation: : ___/___/___
4. Where cancellation was due to accident, illness or death, please state the name of the person whose accident, illness or death necessitated the cancellation.
 - a) Name:
 - b) Relationship to insured:
 - c) Amount claimed for irrecoverable prepaid travel costs (*):

D. LUGGAGE AND PERSONAL EFFECTS CLAIMS DETAILS

1. The following documents are required in support of your claim. Please tick (✓) when attached
 - Police or responsible authority's report
 - Original purchase receipts/proof of ownership
 - Quotation for repair of damage
 - Transport provider's reports
 2. Date notified: ___/___/___ Time: am/pm
 3. Please state exactly what happened:
- (If space is insufficient, please attach details.)

4. What action did you take to recover the lost articles?

.....

.....

(If space is insufficient, please attach details.)

5. Which responsible authority (eg. police) was notified?

Location:

6. Date of loss: ___/___/___ Time: am/pm

7. Do you currently have other insurance on the property lost or damaged? YES NO

If "YES", please give details

Name of insurer: Policy no.

8. If you are entitled to recover losses from any other insurance policy, airline, or other source, please do so and give details of amounts recovered.

.....

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(If space is insufficient, please attach details.)

9. **Items lost or damaged**

FULL DESCRIPTION OF ARTICLES(S) AND DETAILS OF LOSS OR DAMAGE WHERE APPLICABLE	PLACE OF PURCHASE	DATE OF PURCHASE	ORIGINAL PURCHASE PRICE *	AMOUNT CLAIMED *

(If space is insufficient, please attach details.)

E. MEDICAL CLAIMS DETAILS

1. The following documents are required in support of your claim. Please tick (✓) when attached

- Original medical/hospital accounts
- Accounts in support of accommodation expenses
- Medical certificate supporting need for altered travel plans
- Copy of travel itinerary

2. Date of accident, illness or circumstance: ___/___/___ Time:am/pm

Country:

3. Particulars of claim:.....

4. Are you a member of a private health fund? YES NO
 If "YES", please give details
 Name of fund:
5. If your claim arises from injury or illness, please specify the nature of such injury or illness:

6. Name of person whose injury or illness cause additional expenditure:
7. Their relationship to you:
8. Has the illness or injury occurred before? YES NO
 If "YES", please supply the following details
 Usual doctor's name: Telephone ()
9. Date of last visit: ___/___/___
10. If additional expenses have been incurred as the result of an accident, illness or death of a person, please state their relationship to you:

Expenditure for which reimbursement is claimed		Amount claimed *
1. Provider (eg. Dr J Smith, Bali Hospital etc.)	Services	
2. Additional expenses		
3. Cancellation/lost deposits (please attach documents from your travel agent showing cancellation charges)		
Total		

F. MEDICAL AUTHORITY

With regards to medical, cancellation and/or additional expenses claims:

I hereby authorise any hospital, physician or other person who has attended or examined me to furnish to QBE or its representative any and all information in respect of treatment given for:

.....

A photostat copy of this authorisation shall be considered as effective and valid as the original.

Name of usual doctor:

Address of usual doctor:

.....

COMPULSORY COMPLETION FOR ALL CLAIMS

G. DECLARATION

I/We declare that:

1. The information and answers given above are correct to the best of my/our knowledge and belief.
2. I/We understand the claim may be refused or reduced if information is withheld.
3. I/We authorise QBE to disclose information contained herein to QBE's advisors, reinsurers and to other insurers. I/We authorise QBE to obtain from any other party information that is, in QBE's view relevant to this claim.

Signature of insured:

Date: __/__/__

H. MEDICAL CERTIFICATE – COMPLETION BY DOCTOR

To be obtained at the claimant's expense from the patient's usual medical practitioner in this country (or specialist where applicable) in all cases of medical claims and cancellation or additional expenses claims resulting from accident, illness or death.

- 1. Name of person to whom this certificate applies (ie. the person whose accident, illness or death necessitates the completion of this certificate)
 Age:
- 2. Are you his/her usual medical attendant? YES NO
 If "YES", for how long?
- 3. Please give precise details of the nature of the illness or injury

- 4. Please state the date of the onset of the illness, or the dates on which the injuries were sustained: / /
- 5. Please state the date you were first consulted for this condition: / /
- 6. Have you previously treated this patient for the same/similar/related condition as described above? YES NO
 If "YES", please state when:
- 7. To the best of your knowledge has any other doctor previously treated this patient for the same/similar/related condition? YES NO
 If "YES", please state the last time, and what treatment and/or medication was prescribed

- 8. Was the patient advised to continue this treatment and/or medication whilst away? YES NO
- 9. Are you prepared to certify that solely due to the condition described above, the claimant(s) is/are compelled to cancel the holiday arrangements? YES NO

I certify that the foregoing statements are correct:

Doctor's name: Telephone ()

Doctor's address:

Doctor's qualification:

Doctor's signature: Date: .. / .. / ..



Asia Pacific Head Office

Level 7, 345 George Street
Sydney N.S.W. 2000
Australia

Tel: +612 9375 4444
Fax: +612 9375 4070
www.qbe.com/asiapacific

Licensed insurers for the Pacific Islands region:

Fiji

QBE Insurance (Fiji) Limited
QBE Centre
Victoria Parade
GPO Box 101
Suva, Fiji

Tel: + (679) 331 5455
Fax: + (679) 330 0285
Info: info.fiji@qbe.com
www.qbe.com/asiapacific

PNG

QBE Insurance (PNG) Limited
QBE Building
Musgrave Street
P O Box 814, Port Moresby
Papua New Guinea

Tel: + (675) 3212 144
Fax: + (675) 3214 756
Info: info.png@qbe.com
www.qbe.com/asiapacific

Solomon Islands

QBE Insurance (International) Limited
Panatina Plaza
Prince Philip Highway
P.O. Box 764
Honiara
Solomon Islands

Tel: + (677) 38884
Fax: + (677) 38887
Info: info.sol@qbe.com
www.qbe.com/asiapacific

Vanuatu

QBE Insurance (Vanuatu) Limited
La Casa, D'Andrea Building
Port Vila
P.O. Box 186
Vanuatu

Tel: + (678) 22299
Fax: + (678) 23298
Info: info.van@qbe.com
www.qbe.com/asiapacific

French Polynesia

QBE Insurance (International) Limited
Immeuble Gallieni
Front de Mer
P.O. Box 283
Papeete, Tahiti – French Polynesia

Tel: + (689) 50 66 00
Fax: + (689) 50 66 01
Info: info.fp@qbe.com
www.qbe.com/asiapacific

New Caledonia

QBE Insurance (International) Limited
5 Rue Anatole-France
BP 449
98845 Noumea-Cedex
New Caledonia

Tel: + (687) 246300
Fax: + (687) 287717
Info: qbe@qbe.nc
www.qbe.com/asiapacific

For literature in use in the French Territories above,
please contact the local QBE office in each of these countries.



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