QBE Travel Claim

QBE Pacific Islands

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) Pty Limited	
Vanuatu	QBE Insurance (Vanuatu) Limited	

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

6. Jurisdiction

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 exclusive 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 exclusively justiciable before the Supreme Court of Vanuatu.

Compulsory completion for all claims

B. Insured details

Name of insured					
Address					
Private tel. no		**Business tel. no**		**Mobile tel. no**	
Fax no		**email**			
Occupation				**Policy no**	
Travel agent				**Tel. no**	
Date of booking travel arrangements		**Date of departure**		**Date of return**	

Have you made previous claims for travel insurance? If "Yes", please give full details below. ☐ Yes ☐ No

Name of insurer	Date of claim

Only complete relevant sections pertaining to your claim.

C. Cancellation / Loss of deposit claims details

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

- ☐ **Doctor's certificate (see Sections E.1. and H)**
- ☐ **Travel agent's letter confirming details of tour costings and cancellation charges**
- ☐ **Transport provider's reports**

2.Reason for cancellation

TRAVEL CLAIM PAC 7/17

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**

Date notified **Time**

3. Please state exactly what happened. (If space is insufficient, please attach details and a sketch if necessary.)

4. What action did you take to recover the lost articles? (If space is insufficient, please attach details and a sketch if necessary.)

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

Location

6. Date of loss **Time**

7. Do you currently have other insurance on the property lost or damaged? If "Yes", please give details. ☐ Yes ☐ No

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. (If space is insufficient, please attach details and a sketch if necessary.)

9.Items lost or damaged (If space is insufficient, please attach details and a sketch if necessary.)

Full description of articles(s) and details of loss or damage where applicable	Place of purchase	Date of purchase	Original purchase price *	Amount claimed *

E. Medical claims details

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

- ☐ **Original medical/hospital accounts**
- ☐ **Accounts / Receipts 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** **Country**

3. Particulars of claim

4. Are you a member of a private health fund? If "Yes", please give details ☐ Yes ☐ No

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 caused additional expenditure:

7. Their relationship to you:

8. Has the illness or injury occurred before? If "Yes", please supply the following details: ☐ Yes ☐ No

Usual doctor's name **Tel no**

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

1. Provider *(eg. Dr J Smith, Bali Hospital etc.)*	**Services**	**Amount claimed ***

2. Additional expenses	**Amount claimed ***

3. Cancellation/lost deposits *(please attach documents from your travel agent showing cancellation charges)*	**Amount claimed ***
Total	

F. Medical authorisation

With regards to medical, cancellation and/or additional expenses claims:
I hereby authorise any hospital, physician or other person who has attended me to furnish QBE or its representatives with 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

Name of insured

Signature

Date

Compulsory completion for all claims

G. Signature and 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 hauthorise 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: **Tel no**

Doctor's address

Doctor's qualification

Doctor's signature

Date

Fiji

QBE Insurance (Fiji) Limited

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