AHI		Accident & Health International Underwriting Pty Ltd (AHI) GPO Box 4213 Sydney NSW 2001 ABN: 26 053 335 952 AFS Licence No: 238261	T. +61 2 9251 F. +61 2 9252 E. claims@ah www.ahiinsur	4385 iinsurance.com.au			
Claim Form Travel Insurance		Important: Please read before 1. This form consists of several required in order to avoid dela 2. Please note that Sections 1, 2 3. Note: This form can be comp 4. The issue of this form is not a	sections. Please ays with your cla 2, 3, 4, 5 & 12 are leted electronica	e provide answers to im. e compulsory. Illy. If completing this			print.
01. Your Details		All Questions Require Complet	ion				
Policy Number Expiry Date		Name of Insured Comp	any				
Your Position CEO/COO Director Employee Title Given Name(s) Family Name	Spou	ise Dependent (Child	Other Gender M Date of Birth	F	Other	
Residential Address (cannot be a PO Box)	Suburb		State		Postcod	e	
Email Address	Daytime Co	ontact Number	Alternative	e Number			
Are you able to claim through any other source? If Yes, please provide details	Yes	No					
Have you made previous travel insurance claims? If Yes, please provide details	Yes	No					
02. Payment Details		Compulsory					
Please provide bank and account details for payment Account Holder's Name							
BSB Number (6-Digits) Account Number		Bank					
(Alternatively supply a deposit slip noting the following inform	ation)						
03. GST Declaration		Must be completed only in resp • Each company owned item • Any other expenses where Au		ncurred by the comp	any.		
Are you registered for GST Purposes? Yes If Yes, What is your ABN?	No	Have you ever claimed, or are y (ITC) in respect to GST paid on claim is being made?				Yes	No
		If Yes, what percentage of ITC di	id you claim or are	e you entitled to claim	?		
Claim Form Travel Insurance		Page 1 of 6					

04. Travel Information				Compulsory			
Departure Date				Return Date			
Departure City				Destination City			
Departure Country				Destination Country			
Reason for Travel Business / Work	Holiday	Combination	Other				
05. Details of Incide	nt			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							

06. 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 Comp	oany contacted?	Yes	No
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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 (use separate sheet if insufficient space)	Amount Claimed (Please state currency)

07. Lost, Stolen or Damaged Luggage & Personal Effects

If applicable

Was the incident reported to Police or any other authority? Na No If Yes, please provide report / Incident No. If No, please provide explanation: Were articles lost by a carrier? Ns No Absent The Warsaw Convention & The Montreal Conventions imposes a liability upon the carrier and you should claim against them first. No Were all the missing articles your property? Yes No If No, Who is the owner? Have you lodged a claim or complaint against any Carrier/A killine or other authority or against any individual responsible for the loss or damage to your property? Yes No If Yes, please provide details and attach correspondence: If No, please provide explanation: No If you are claiming for spectacles, detainable against your property? Yes No Membership Number If you are claiming for spectacles, detainable against your private health fund? Name of Fund Membership Number If you are claiming for spectacles, detainable against your private health fund? Yes No Currency Date of Your Arrival Time AM/PM Compensation Paid by Carrier Currency If applicable If applicable If applicable If applicable If applicable Respected for detainaged and in addition a figure for the damage where applicabl	 In the event of loss or damage occurring v (airlines, bus companies, etc) the carrier si a Property Irregularity Report obtained an Full description of articles lost or damage of damage, full particulars of purchase print purchase are to be entered on the statement with proof of lost or damaged goods (e.g.) Certificates, Credit Card Statements). 	 You should obtain an estimate for repairs where feasible or written confirmation from a competent repairer or dealer that the articles are damaged beyond economic repair. All optical expenses must first be submitted to your health fund, if applicable. Lost/Stolen goods should be reported to the Police. 						
Were articles lost by a carrier? Yes No Acte: The Warsaw Convention & The Montreal Conventions imposes a lability upon the carrier and you should claim against them first. Were all the missing articles your property? Yes No If No, Who is the owner? Have you ledged a claim or complaint against any Carrier/ Airline or other authority or against any individual responsible for the loss or damage to your property? Yes No If Yes, please provide details and attach correspondence: If No, please provide explanation: No If you are claiming for spectacles, the meaning align at my property? No Membership Number If you are claiming for spectacles, the meaning align at my prove the mean plain against your and the mean plain against your are daimable against your prove the mean plain against my mean the mean plain against them first. Membership Number OB. Delayed Baggage I'me MM/PM Compensation Paid by Carrier Currency If applicable I'maplicable I'maplicable Date of Your Arrival Time AM/PM Compensation Paid by Carrier Currency Statement of Claim Adult description of the article(s) to is or damaged and in addition a fully description of the article(s) to is or damaged and in addition a fully description of the damage where applicable. Plate of Luggag	Was the incident reported to Police or any o	other authorit	y?	Yes	No			
Note: The Warsaw Convention & The Montreal Conventions imposes a liability upon the carrier and you should claim against them first. Were all the missing articles your property? Yes No If No, Who is the owner? Have you lodged a claim or complaint against any Carrier/Alrine or other authority or against any Yes No No If Yes, please provide details and attach correspondence: If No, Please provide explanation: No No If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? No Membership Number Currency O8. Delayed Baggage Yes No May Pleatth Insurer Currency Oate of Your Arrival Time AM/PM Compensation Paid by Carrier Currency Date of Luggage Arrival Time AM/PM Compensation Paid by Carrier Currency Statement of Claim Time AM/PM Compensation Paid by Carrier Currency Bill description of the class of damage where applicable. Plaese attach relevant documentation to support your claim, e.g. receipts, photographs, manuals. Plaese attach relevant documentation to support your claim, e.g. receipts, photographs, manuals.	If Yes, please provide report / Incident No.			If No, please p	provide explana	ation:		
Were all the missing articles your property? vs No If No, Who is the owner? Have you lodged a claim or complaint against any Carrier/ Airline or other authority or against any individual responsible for the loss or damage to your property? vs No If Yes, please provide details and attach correspondence: If No, please provide explanation: Vs No If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? Membership Number Membership Number Os. Delayed Baggage Vs No Mraunt Paid by Health Insurer Currency Date of Your Arrival Time AM/PM Compensation Paid by Carrier Currency Date of Luggage Arrival Time AM/PM Compensation Paid by Carrier Currency Statement of Claim Time AM/PM State spearate sheet if insufficient room Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the damage where applicable. Full description of article/s & details of damage where Original Cost Date and Place of Purchase Hastem been ITC% Amount Giuded to groupe where Original Cost Date and Place of Purchase Hastem been ITC% Amount	Were articles lost by a carrier?			Yes	No			
Have you lodged a claim or complaint against any Carrier/ Airline or other authority or against any yes No No If Yes, please provide details and attach correspondence: If No, please provide explanation: If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? Name of Fund Membership Number If you are claimable against your private health fund? Yes No Amount Paid by Health Insurer Currency O8. Delayed Baggage If applicable If applicable Currency If applicable Date of Your Arrival Time AM/PM Compensation Paid by Carrier Currency Date of Luggage Arrival Time AM/PM Compensation Paid by Carrier Currency Statement of Claim Time AM/PM Compensation Paid by Carrier Currency Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a plate to receipts, photographs, manuals. Full description of article/s & datails of damage where Original Cost Date and Place of Purchase Haa item been ITC%	Note: The Warsaw Convention & The Mon	treal Conver	ntions imposes a l	iability upon th	e carrier and y	ou should cl	aim against th	em first.
Individual responsible for the loss or damage to your property? If so No If Yes, please provide details and attach correspondence: If No, please provide explanation: Name of Fund Membership Number If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? O8. Delayed Baggage If applicable Date of Your Arrival Time AM/PM Compensation Paid by Carrier Currency If applicable Date of Luggage Arrival Time AM/PM Statement of Claim Fill description of article/s & details of damage where Arrival Original Cost price Date and Place of Purchase Has item been ITC% Amount Currency Place and Place of Purchase Has item been ITC% Amount Currency Italia tem been Italia tem been Itali	Were all the missing articles your property?		Yes No	If No, Who is t	the owner?			
Name of Fund Membership Number If you are claiming for spectacles, dentines of animable against your private health fund? Yes No Amount Paid by Health Insurer Currency O8. Delayed Baggage If applicable Date of Your Arrival Time AM/PM Compensation Paid by Carrier Currency Date of Luggage Arrival Time AM/PM Compensation Paid by Carrier Currency Statement of Claim Time AM/PM Compensation Paid by Carrier to damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of th				authority or aga	inst any	Yes	No	
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Date of Your Arrival Time AM/PM Compensation Paid by Carrier Currency Jate of Luggage Arrival Time AM/PM If applicable Date of Luggage Arrival Time AM/PM Statement of Claim Statement of Claim Full description of article/s & details of damage where Original Cost Date and Place of Purchase Has item been ITC% Amount CUR Full description of article/s & details of damage where Original Cost Date and Place of Purchase Has item been ITC% Amount CUR	dentures, or a hearing aid, are these items claimable against your	Yes No			surer		p Number	
Date of Luggage Arrival Time AM/PM Statement of Claim Attach separate sheet if insufficient room Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the article(s) lost or damaged and in addition a fully detailed description of the damage where applicable. Please attach relevant documentation to support your claim, e.g. receipts, photographs, manuals. Full description of article/s & details of damage where Original Cost Date and Place of Purchase Has item been ITC% Amount CUR	08. Delayed Baggage			If applicable				
Statement of Claim Attach separate sheet if insufficient room Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the damage where applicable. Please attach relevant documentation to support your claim, e.g. receipts, photographs, manuals. Full description of article/s & details of damage where Price Date and Place of Purchase Has item been replaced ITC% Amount CUR Claimed	Date of Your Arrival Time		AM/PM		n Paid by Carrie	er Cur	rency	
Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the damage where applicable. Please attach relevant documentation to support your claim, e.g. receipts, photographs, manuals. Full description of article/s & details of damage where applicable (provide evidence) Original Cost Place of Purchase Has item been replaced ITC% Amount Claimed CUR	Date of Luggage Arrival Time		AM/PM					
applicable (provide evidence) Price replaced Claimed	Statement of Claim			Give a full des fully detailed o	scription of the description of t relevant docur	article(s) lost he damage w mentation to s	or damaged a here applicab	le.
				receipts, phot	ographs, manu	als.		
e.g Dell Latitude x150 - Cracked Monitor – photo #1 \$2,600 AUD 26/06/2018 - Dell website No 65% \$2,600 US			Date and Place of Pur		Has item been			CUR

e.g Dell Latitude x150 - Cracked Monitor – photo #1	\$2,600 AUD	26/06/2018 - Dell website	No	65%	\$2,600	US

09. Additional And/Or 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 (Please supply Full Details)	Amount Claimed (Please state currency)

Date of Expense	Forfeited Expenses (Please supply Full Details)	Amount Claimed (Please state currency)

10. Hire Car Expenses

If applicable

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

		Name of Vehicle Hire Company							
Car	Other								
Title	Driver's	Full Details							
Rental Ve	hicle Excess	Currency	Actual Repair Costs	Currency	Amount you are claiming	Currency			
\$		\$:	\$				

11. Cancellation / Loss of Deposits

If applicable

If you are claiming because you cancelled your trip PRIOR to depart	re, as a result of injury, illness or death, you MUST have the Medical
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- 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

	ATH, PLEASE ATTACH DEATH CERTIFICAT						
Title Given Name(s)							
Family Name		Relationship of per	son to claimant				
Amount Paid \$ If no refund amount is noted (Currency Amount Refunded \$ please state why (you must obtain all refund		Amount Claiming \$	Currency			
12. Declaration		Compulsory					
General Insurance Code of Practice AHI proudly support the General Insurance Code of Practice (the 'Code'). The purpose of the Code is to raise the standards of practice and service in the general insurance industry. For further information on the Code, please visit www.codeofpractice.com.au. Complaints and Disputes Resolution If you have a dispute and after talking to AHI, 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 15 business days in accordance with the General Insurance Code of Practice. If you still remain dissatisfied after proceeding with the above, our process includes advising you on how to contact the insurance industry's external independent complaints scheme, the Australian Financial Complaints Authority (AFCA). Access to this scheme is free of charge to you.		Privacy Declaration I/We agree that, by submitting this form, the personal information I/we provide to AHI in this form or otherwise may be collected, held, used and disclosed in the manner set out in the AHI Privacy Policy found at www.ahiinsurance.com.au, including for the processing of this claim.					
By signing and dating the form above once completed, you declare the follow		Signature of Claima	ant				
Declaration: I/We certify that the information given complete. No information likely to affect understand that this claim may be refus or concealed.	ot this claim has been withheld. I/We	Date					
Authority I authorise any hospital and/or physicia with copies of medical records or of m		Signature of the Ins	sured (if other than claimant)				
		Date					



Medical Certificate

Accident & Health International Underwriting Pty Ltd (AHI) GPO Box 4213 Sydney NSW 2001 ABN: 26 053 335 952 AFS Licence No: 238261

T. +61 2 9251 8700 F. +61 2 9252 4385 E. claims@ahiinsurance.com.au

www.ahiinsurance.com.au

Medical Certificate				The claimant must obtain at own expense from the patient's usual doctor in all cases 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 enquiries				
13. Patient Details			Compulsory					
Title Giv	en Name(s)				Da	te of Birth		
Family Name								
1. Are you his/her usual medi	cal attendant?	Yes	No					
2. If Yes, for how long?		Days	s	Months	Years			
3. Please give precise details	s of the nature of the illness or injury	<u>.</u>						
4. Start date of onset of illne	ss, or date							
-	ere first consulted in relation to the nd, in your opinion, how long the cor nsultation.	ndition						
First Consultation Date	Condition has been preser	nt prior to c	consultatio	n for:				
6 Are you propored to cortifi	, that apply due to the condition do	ooribod in a	upotion 2	the eleimente	washwara aamaa	llad		

6. Are you prepared to certify that solely due to the condition described in question 3, the claimants was/were compelled Yes No to cancel the travel arrangements?

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	Qualification		Signature
Address	Phone	Fax	Date