

QANTAS AIR CREW CLUB GROUP TRAVEL INSURANCE REPORT FORM

1. This form must be fully completed in the sections applicable to your claim and signed.
2. The Privacy Consent section must also be signed for all claims.
3. For baggage/business property, electronic equipment and money/travel documents claims - attach invoices, valuations or receipts to support the value of the items being claimed and, most important, written confirmation from the police, Local Government or Carrier supporting your notification of the loss (if applicable).
4. For medical claims – enclose all the relevant documents to support your claim. Medical reports may be necessary, therefore the Medical Authority on this form must also be signed and completed by you.
5. For damage or loss by the carrier, cancellation and curtailment, loss of deposits or additional expenses claims – obtain written advice from the carrier involved as to the amount of the refund obtainable from them as a result of the damage or loss of articles, cancellation or curtailment of the journey, loss of deposits or additional expenses.

The issue of this form is not an admission of liability or a waiver of rights and is without prejudice.

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Name of Traveller (Mr/Mrs/Miss/Ms): _____

Occupation: _____ Date of Birth: _____

Address: _____ **Email (Important):** _____

Telephone: Home: _____ Business: _____ Mobile: _____

Full Policy No. and Staff ID No.: _____

IF YOUR CLAIM RELATES TO LEISURE TRAVEL, PLEASE ATTACH YOUR TRAVEL ITINERARY

Please note if the person mentioned above is a Nominated Group A Staff Travel Beneficiary, a copy of the beneficiary list is required.

Did the loss occur on (please tick): Duty Travel Leisure Travel

SETTLEMENT DETAILS

Bank Draft in the following currency _____, or;

Direct to Bank Account Details Below:

Bank/Financial Institution: _____ Address: _____

Account Name: _____

BSB Number: _____ Account Number: _____

SWIFT: _____

PRIVACY STATEMENT, MEDICAL AUTHORITY AND DECLARATION

Fullerton Health Corporate Services (FHCS)

FHCS is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). FHCS will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

FHCS will take all reasonable steps to ensure that personal information held by FHCS is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

FHCS has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.fullertonhealth.com.au and send to privacy@fullertonhealthcs.com.au.

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, FHCS has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to FHCS using and disclosing my personal information pursuant to FHCS's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to FHCS's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to FHCS such personal information (including health information) as FHCS in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to FHCS in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, FHCS may not be able to process or assess my claim.

I appoint FHCS to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant:

Date: | |

Name of Claimant:

Signature of Witness (any adult person):

Date: | |

Name of Witness:

PERSONAL ACCIDENT & SICKNESS (INCLUDING DENTAL) AND OVERSEAS MEDICAL & ADDITIONAL EXPENSES CLAIM

Type of Injury or Sickness		Date of Accident or Commencement of Sickness
If Injury – Give full details of Accident		
Date of First Medical Consultation	Name of Doctor or Hospital	
Details of other treatment by Doctors/Hospital		
Dates in Hospital	Admitted / / am/pm	Discharged / / am/pm
List the Country and the currency of the Country in which you incurred the medical costs	Country:	Currency: Total Amount
	Country:	Currency: Total Amount
Have you ever suffered from the same or similar complaint in the past?	Yes / No	
If Yes, give details, dates, names and addresses of treating physicians		
Name and address of usual treating doctor.		
How long has the doctor been known to the patient?		

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM:

1. Original Doctor/Hospital accounts and receipts
2. Original Doctor's certificate

Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason.

CANCELLATION AND CURTAILMENT EXPENSES, LOSS OF DEPOSITS CLAIM

What was the reason you could not commence or complete your proposed journey?	
Was the cancellation as a result of Injury/Sickness to yourself?	Yes/No
Was the cancellation as a result of Injury/Sickness to some other relative or person as defined in the Policy?	Yes/No
If Yes : Name	Address
Relationship	Age
Nature of complaint preventing travel	
Date you advised Travel Agent to cancel bookings	/ /
Amount of Deposit paid and date paid	\$ Date
Balance of Full Fare and date paid	\$ Date
Value of Forfeited Portion of Journey (if applicable)	\$
Refund received on cancellation	\$
Full amount being claimed	\$
Were any alternative arrangements offered? If so, give details	
Did you accept any of the alternative arrangements?	Yes/No
What additional fares did you incur as a result of the arrangement?	

- You will also need to fill out the Missed Transport, Cancellation & Curtailment Claim section on the following page.

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM:

1. Original receipts and/or Tickets relating to additional expenses incurred.
2. Proof of cause ie. Original Doctor/Hospital certificate relating to Injured or Sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport.

Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason.

PERSONAL LIABILITY CLAIM

Bodily Injury – Provide relevant details – Name Address of injured Party and details of Injury	
Damage to Property – List all Property Damage together with Name and Address or Party claiming damage against you	
Is the Injury or Damage related to a travelling companion?	Yes/No
Do you consider you were at fault?	Yes/No
If so, why	

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM:

1. Letter or document of a claim made on you.

Failure to provide these items may result in delays in processing your claim. It is impossible to provide any of the supporting documents please advise the reason.

MISSED TRANSPORT, CANCELLATION & CURTAILMENT CLAIM

(For additional travel and accommodation incurred during the journey)

Reason for incurring additional travel or accommodation expenses			
List the Country and the Currency of the Country in which you incurred the costs	Country:	Currency:	
List specifically the additional TRAVEL expenses	Details	Amount	
		A\$	
		A\$	
		A\$	
	TOTAL	A\$	
List Specifically the additional ACCOMMODATION expenses	Details	Amount	
		A\$	
		A\$	
		A\$	
	TOTAL	A\$	
Were these expenses incurred as a result of Injury or Sickness as claimed in Part 1? Yes/No			
If these expenses were incurred as a result of Injury or Sickness to any other person, please give details of cause, name, address, age of person and relationship to you	Name		Age
	Address		Relationship
Cause			

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM:

1. Receipts and/or tickets relating to additional expenses incurred.
2. Doctor/Hospital certificate specifying exact nature of condition suffered by injured/sick person.
3. Letter from the travel agent or carrier verifying reason for additional expenses and/or any refund applicable.

Failure to provide these items may result in delays in processing your claim. It is impossible to provide any of the supporting documents please advise the reason.

RENTAL VEHICLE EXCESS WAIVER CLAIM

Please provide a full description of the circumstances of the incident giving rise to the claim:

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM:

1. The Rental Agreement.
2. Notice from the Rental Company in respect of the excess or deductible.
3. Documentation evidencing payment of excess or deductible.

Failure to provide these items may result in delays in processing your claim. It is impossible to provide any of the supporting documents please advise the reason.

PERSONAL ACCIDENT & SICKNESS – ACCIDENTAL DEATH CLAIM

What was the cause of death?

When did the accident occur?

Time

am/pm

Was a coronial inquest held or is one to be held? Yes/No

If yes, give details

Place where inquest held

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM:

1. The original policy document.
2. Original of the death certificate which will be returned to you.
3. Copy of the Coroner's depositions and findings (if applicable).
4. Original birth certificate which will be returned to you

Failure to provide these items may result in delays in processing your claim. It is impossible to provide any of the supporting documents please advise the reason.