

# TRAVEL INSURANCE

## CLAIM REPORT



Please retain this page for your information.

## IMPORTANT

### Please read this before completing the report.

Please read the claim report in full before completing the details.

- An excess may apply to the claim you are making. You should read your policy to find out if one applies.
- Please answer all the questions that apply to your loss and make sure that you have signed the report before sending it. This will help us process your application quickly.
- There is a 'check list' at the end of this report. Please use it to make sure you have given us all the information we require to review your claim.
- If you have any questions about your claim, please contact CGU on tel 13 24 80 (13 CGU 0)

### When complete, please forward the report to:

Mail: CGU Insurance GPO Box 2852 Melbourne VIC 3001 or  
Email: Claims@cgu.com.au or  
Fax: 1300 033 392 or  
our agent or your broker or your CGU Insurance office

## HOW YOU CAN RESOLVE A DISPUTE WITH US

Our dispute resolution system is free and works like this:

1. Please advise the staff at your CGU Insurance office on 13 24 80 if you are dissatisfied with:
  - our decision on your claim,
  - our handling of your claim,
  - the services of our loss adjuster or investigator.
2. The staff member will try to resolve the problem.
3. If unable to resolve it, the staff member will refer it to the supervisor or manager for attention. A decision concerning your complaint will be made within 15 days of receipt.
4. If this fails to resolve your problem, you may request that the problem be referred to our internal dispute resolution staff. They will investigate the dispute and try to reach a satisfactory outcome with you, normally within 15 days of the date you requested a referral.
5. If you do not accept our decision, you may take the problem to the Australian Financial Complaints Authority (AFCA), for an independent investigation. The AFCA can assist with private consumer and some small business type claims.

The telephone number for the Australian Financial Complaints Authority is 1800 931 678.

**More detailed information about this process is available from your CGU Insurance office.**



# TRAVEL INSURANCE CLAIM REPORT

## The insured (please use block letters)

Surname (Mr, Mrs, Ms, Miss, Dr.)

Given name(s)

Email

### CGU Insurance use only

Claim no.

### Are you registered for GST purposes?

No  Yes  What is your ABN?

Have you claimed or do you intend to claim an input tax credit on the GST amount applicable to this policy?

No  Yes  Is the amount claimed or to be claimed less than 100% of the GST applicable to the premium? No  Yes  Specify the percentage amount claimed or intended to be claimed  %

Address

 Postcode 

Private telephone no.

Business telephone no.

Date of birth

Occupation

Policy or Certificate no.

Date holiday deposit paid

## Circumstances of claim

### This section must be completed:

Date of loss, accident, illness or cancellation.  /  /  Time  a.m.  p.m.

Please describe how the loss occurred. Include details of the loss, accident, illness or reason for cancellation.  
(If insufficient space, please attach statement.)

Are you entitled to claim under any other policy of insurance or private health fund?

No  Yes  Give name and address

 Postcode 

Have you made any previous claims for Travel Insurance?

No  Yes  Give details

## Luggage and travel documents details

Please give the exact place where the loss or theft happened

What did you do to recover the lost or stolen items?

If your luggage was lost during a flight or by an airline, please give the name of the airline and the person you contacted

Name of airline and contact name

Telephone no.



If you reported your loss or theft to someone in authority, please give details (e.g. police)

Reference no.

Name of station and contact name

Telephone no./Fax no.




Address

Postcode

Give details of Household Contents Insurance


Policy no.

Company



**Please note that depreciation and an excess may apply to your claim**

**Please also note that proof of ownership is required**

Only complete this column if the items being claimed for are used in connection with your GST registered business. 

Full description of the article(s) claimed	Name and address where purchased	Date of purchase	Input Tax Credit you can claim on the purchase of these items as a % of the total GST payable.	Original purchase price	Replacement/repair cost
		D D / M M / Y Y	%	\$	\$
		D D / M M / Y Y	%	\$	\$
		D D / M M / Y Y	%	\$	\$
		D D / M M / Y Y	%	\$	\$
		D D / M M / Y Y	%	\$	\$
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### Additional expenses, travel delay, missed connection, rental vehicle excess, cash in hospital, loss of income

Details of expenses incurred (if insufficient room please attach list)	Date expenses incurred	Amount claimed (currency)	Type of service
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		

Place and country of circumstances of claim

If your travel was delayed by your transport provider did they provide you with alternate accommodation/meals?

No  Yes

### Resumption of journey, interruption, curtailment and cancellation

Details of expenses incurred (if insufficient room please attach list)	Date expenses incurred	Amount claimed (currency)	Type of service
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		
	DD / MM / YY		

Was the resumption of journey, interruption and curtailment or cancellation due to your travelling companions or your illness?

No  Yes  ► Please have the Medical Certificate on page 7 completed.

Was the resumption of journey, interruption, delay or cancellation due to the death, injury or illness of a relative or a business partner?

No  Yes  ► 1. Please have the Medical Certificate on page 7 completed.

2. Name of person

Date of birth

Relationship




3. If it was a death, please supply a full death certificate with the medical certificate.

If you are claiming for cancellation please tell us:

Date of cancellation

Date your journey was booked

## Medical expenses

Details of expenses incurred (if insufficient room please attach list)	Date expenses incurred	Amount claimed (currency)	Type of service
	D D / M M / Y Y		
	D D / M M / Y Y		
	D D / M M / Y Y		
	D D / M M / Y Y		
	D D / M M / Y Y		
	D D / M M / Y Y		
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	D D / M M / Y Y		

If your medical expenses were the result of an illness or the recurrence of an injury, please have the Medical Certificate on page 7 completed.

Place and country where the medical expenses were incurred

Has the claimant suffered this complaint before?

No  Yes   Give details including dates.

Name of person treated

Age

Relationship to insured

Type of injury/illness or disease

Date of commencement of injury/illness or disease

Name of doctor/hospital

Date of first medical consultation



# MEDICAL CERTIFICATE

The following Medical Certificate must be completed by the usual doctor or dentist of the sick or injured person. This applies where cancellation of the journey is a result of your doctor's recommendation or there has been an early return or request for the resumption of journey following the death, injury or illness of a relative or business partner.

If the claim is as a result of illness the report must be from a doctor who has treated the person for at least 12 months.

1. Name of person to whom this certificate applies (i.e. the person whose accident, illness or death caused the cancellation of the holiday)

2. Age                      Date of birth

 DD / MM / YY

3. Are you the person's usual medical practitioner?

No  Yes  If so, for how long?

4. Please provide details of the accident or illness.

5. When did the accident happen or the illness commence?

 DD / MM / YY

6. a. When were you first consulted for the condition described in question 4?

 DD / MM / YY

b. In your opinion how long had that condition been present before you were consulted?

7. a. What treatment, if any, has the person previously received for that condition or any related condition?

b. When did the person receive the treatment? From  DD / MM / YY to  DD / MM / YY

8. Is the person suffering from any chronic disease or illness or does the person have any other physical defect or disability?

No  Yes  If so please provide details

9. Are you prepared to certify that, solely due to the condition described in question 4, the claimant(s) is/are compelled to cancel their travel arrangements?

No  Give details

Yes  Give details

10. a. At the time the person sought treatment for the condition in question 4, was it life threatening? No  Yes

b. Did it become life threatening at any time and, if so, when? No  Yes  Date  DD / MM / YY

11. Is the condition in question 4 directly or indirectly related to, or caused by, any other pre-existing condition/s?

No  Yes

## Declaration - medical practitioner

The medical practitioner is respectfully requested to give as much detail as possible in order to assist the claimant and avoid the necessity of additional enquiries. **I certify that the foregoing statements are correct.**

Signed

Date

Please print name

Address

Postcode

Qualification

## Declaration - insured

**Medical Authority** - I hereby authorise any hospital, physician or other person who has attended or examined me, to give CGU INSURANCE, or its representative, any, and all information in respect of treatment given for:

Name

Signature of applicant

Date

Doctor's name

Doctor's address

Postcode

**This authorisation is valid for a period of three months from the date of my signature.  
A photocopy of the authorisation shall be considered as effective and valid as the original.**

## Declaration

I declare that to the best of my knowledge and belief, the information in this form is true and correct and I have not withheld any relevant information.

I/we agree that, by submitting this form, the personal information I/we provide to CGU Insurance in this form or otherwise may be collected, held, used and disclosed in the manner set out in the CGU Privacy Policy found at [www.cgu.com.au/privacy](http://www.cgu.com.au/privacy), including for processing this claim.

Signature of Insured

Date

Signature of second insured (if your are unrelated and have a Partners Plan and both partners are claiming)

Date

Please indicate the number of additional pages attached to this claim report

**When complete please forward the report to the CGU Claims department (see page 2).**



## Checklist

**Please complete the following checklist to make sure you have provided us with all the information we require to process your claim quickly.**

### **To be completed on every claim report form:**

- Insured and policy details (attach a copy of your insurance certificate).
- Circumstances of the claim (page 1).
- Signed declaration.

### **Cancellation, resumption of journey, interruption and curtailment:**

- Complete the bottom half of page 3.
- Attach the original tour operators and airline notice of refund and your receipts for payment of the original tour.
- If your loss was related to a medical condition have the Medical Certificate on page 5 completed.

### **Medical expenses:**

- Complete page 6.
- Have the Medical Certificate on page 5 completed by your usual doctor.
- Sign the Medical Authority on page 6.
- Supply original accounts and receipts as soon as they are available including any refunds from your local health fund.

### **Additional Expenses, travel delay, missed connection, rental vehicle excess, cash in hospital, loss of income:**

- Complete the top of page 3.
- Attach original accounts, receipts, and original itinerary.
- For loss of income, provide a letter from your employer advising the date you were due to return to work and your average net income.
- For hire car excess claims, provide your original car rental agreement.

### **Luggage and travel documents:**

- Complete page 2.
- Supply original reports from the police, airline, hotel or tour guide stating that the loss was reported.
- Supply proof of ownership of any goods lost or destroyed (Original receipts, credit cards, guarantees, valuations, certificates or photographs).
- Supply original repair or replacement quotes.

## CONTACT DETAILS

**Enquiries** 13 24 81

**Claims** 13 24 80

### Mailing address

GPO Box 9902 in your capital city

#### **Sydney**

Tower Two, Darling Park  
201 Sussex Street  
Sydney NSW 2000

#### **Melbourne**

181 William Street  
Melbourne VIC 3000

#### **Brisbane**

189 Grey Street  
South Bank QLD 4101

#### **Perth**

46 Colin Street  
West Perth WA 6005

#### **Adelaide**

80 Flinders Street  
Adelaide SA 5000



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Insurer  
**Insurance Australia Limited**  
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trading as CGU Insurance