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TRAVEL INSURANCE REPORT FORM

Please ensure this Form is completed in all Parts applicable to your claim. The Information Authority and Warranty, on the back, must be completed for all claims.

Supporting documentation required is detailed below each Part.

The issue and acceptance of this Form does not constitute an admission of liability by the Company or a waiver of its rights.

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Name of Insured: (Mr/Mrs/Miss/Ms)

Policy Number
 (The certificate of insurance must be attached to this form)

Address:

Telephone: Home: Business:

Date of Birth: Occupation:

Travel Agent: Date of Booking Travel Arrangements:

Date of Departure: Date of Return:

Name and Address of usual family doctor:

How long has the doctor been known to the patient?

CANCELLATION CHARGES, LOSS OF DEPOSIT 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
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Was the cancellation as a result of Injury/Sickness to some other relative or person as defined in the Policy?	Yes/No
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If so	Name	Address	Relationship	Age
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Nature of complaint preventing travel	
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Date of First Medical Treatment / /	Has the Injured/Sick person had a similar condition in the past?	Yes/No
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Name and Address of Patient's normal Doctor	
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Date you advised Travel Agent to cancel bookings	/ /
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Amount of Deposit paid and date paid	\$	Date
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Balance of Full Fare and date paid	\$	Date
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Value of Forfeited Portion of Journey (if applicable)	\$
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Refund received on cancellation	\$
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Full amount being claimed	\$
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Were any alternative arrangements offered? If so, give details	
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Did you accept any of the alternative arrangements?	Yes/No
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What additional fares did you incur as a result of the arrangement?	
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THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. The Original Tickets/Vouchers if a refund is not obtainable.
2. Doctor's/Hospital Certificate specifying exact nature of condition suffered by Injured/Sick person.
3. Letter from Travel Agent verifying total cost of journey, value of unused portion of journey, cancellation charges incurred and total amount of refund received.

***Failure to provide these items may result in delays in processing your claim.**

OVERSEAS MEDICAL, DENTAL AND/OR HOSPITALISATION BENEFIT 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 family doctor			
How long has the doctor been known to the patient?			
Are you a member of a Private Health Insurance Fund, e.g. Medibank?	Yes/No	Name of Fund	

PLEASE NOTE: All medical accounts must first be lodged with your Private Health Fund, if applicable

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Original Doctor's/Hospital accounts and receipts together with details relating to medical benefit refunds.
2. Original Doctor's Certificate verifying nature of complaint suffered by you.

***Failure to provide these items may result in delays in processing your claim.**

EMERGENCY EXPENSES 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\$	
		A\$	
	TOTAL	A\$	
List specifically the additional ACCOMMODATION expenses	Details	Amount	
		A\$	
		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's/Hospital Certificate specifying exact nature of condition suffered by Injured/Sick person.
3. Letter from 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.**

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? If so give details	Yes/No		
	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 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.**

PERSONAL LIABILITY CLAIM

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

THE FOLLOWING ITEM MUST BE INCLUDED WITH THIS CLAIM*

1. Letters or Demands of a claim made on you.

***Failure to provide this item may result in delays in processing your claim.**

RENTAL VEHICLE COLLISION AND THEFT EXCESS COVER CLAIM

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

THE FOLLOWING ITEM 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.**

INFORMATION AUTHORITY AND WARRANTY

I,
hereby authorise any hospital, physician or other person who has attended me to furnish ACE or its representatives with:-

- (i) Copies of hospital and medical reports/notes;
- (ii) All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment)

I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that the ACE Company relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Date: Signature:

NOTE

*Failure to provide these items may result in delays in processing your claim - if it is impossible to provide any of the items please advise the reason: _____