Budget Direct
simply smarter insurance®

Travel Insurance Claim Form

# Cancellation

**You must register any claim within 30 days of completion of your travel. Please supply original documents of the evidence you intend to rely on for your claim, and send by registered post to ensure delivery.**

## Claimant Details

**Claim Reference** *(if known)*

**Title** *(Mr / Mrs etc)* | **First Name** | **Surname** | **Date of Birth** (/ /)

**Nationality** | **Occupation**

**Medicare Number** | **Parent / Guardian's Medicare Number** *(If medical claim is for a minor)*

**Home Address** | **Home Phone** | **Work Phone** | **Mobile**

**State** | **Postcode** | **Email**

## Policy Details

**Policy Number** | **Date Issued** (/ /) | **Number of Travellers**

**Independent Travel Arrangements:** Yes ☐ No ☐ *If no, provide the following*:*

***Travel Agent and Branch** | ***Tour Operator**

**Date of Booking** (/ /) | **Departure Date** (/ /) | **Return Date** (/ /) | **Total Days**

**Country** | **Resort / Town**

## GST *(for domestic policy claims only)*

**Are you registered for GST and did you claim a GST input tax credit on your premium?** Yes ☐ No ☐

**If yes, what is your input tax credit entitlement percentage:** *(i.e. a full entitlement is 100%)*

**It is against the law to submit a fraudulent insurance claim. If your claim is found to be fraudulent, the claim will be declined and Insurers will pursue recovery through the use of legal action.**

1. I / We hereby declare that all information, answers, and documents given in connection with this claim are true and correct to the best of my / our knowledge and belief. I / We have not omitted any material information, which would affect the Underwriters judgement of the claim. I confirm that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf, and I confirm that I understand that Auto & General Insurance Company Limited will not accept responsibility if any payments are not distributed proportionately to the persons concerned.
2. I / We understand that the information on this form will be passed to or used by Auto & General Insurance Company Limited for my insurance, this includes underwriting, processing, handling claims and preventing fraud and could include passing details to agents or other insurers. This includes access to my previous claims with other insurers.
3. I / We assign all rights to Auto & General Insurance Company Limited and consent to them seeking reimbursement of any medical expenses paid by them.

**For medical related claims:**

4. I authorise any doctor, hospital, travel insurer or other organisation or person having any records or information concerning my medical history or treatment to furnish such records or information as may be requested by Auto & General Insurance Company Limited or their agents. I understand that in executing this authorisation, I waive the right for such information / records to be privileged. I am also aware that such information / records are relevant in the evaluation of my claim and that non-submission could prejudice my claim. A photocopy of this authorisation shall be considered as effective and valid as the original.

**Privacy Statement**

The personal and sensitive information collected in this form, and other information you or third parties provide in connection with this claim will be held, used and disclosed by us to process this claim, compile and analyse data, and resolve claim disputes.

We may have to disclose your personal and other information to third parties who assist us in assessing and processing this claim, including other insurers, health providers, investigators, our specialist advisors, service providers, or as required by law. Your personal information may also be disclosed to third parties in the countries and regions nominated under your policy, or any other regions where you may require assistance. For further information please see our privacy policy or email us at travelhelp@budgetdirect.com.au.

**I have read and fully understand the declarations above (ALL persons claiming must sign)**

**Claimant's Name** | **Signature** | **Date of Birth** (/ /) | **Date** (/ /)

**Claimant's Name** | **Signature** | **Date of Birth** (/ /) | **Date** (/ /)

Please return this claim form to:
**Budget Direct Travel Insurance, PO Box 547, Pyrmont NSW 2009**

## Cancellation

**Reason for cancellation:** *Please select one box only*

**Illness** ☐ **Injury** ☐ **Death** ☐ **Redundancy** ☐ **Jury Service** ☐

**Damage / Theft to Home / Business** ☐ **Other**

**When did you become aware of the need to cancel your holiday:**

**Date** / / **Time** ☐ AM ☐ PM

**When did you inform the airline, accommodation provider, travel agent or tour operator of the need to cancel your holiday:**

**Date** / / **Time** ☐ AM ☐ PM

**If applicable, please give the name of the person who has caused the cancellation and their relationship:**

**Name** **Relationship**

## Details of holiday cost and cancellation charges:

| | |
|---|---|
| **Ticket costs** | |
| **Accommodation costs** | |
| **Pre-booked excursions** | |
| **Deduct refunds received or advised** | |
| **Total amount claimed** | |

## Names and dates of birth of all those cancelling:

| Name | DOB |
|---|---|
| | |
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**Please detail the reasons for cancellation below, giving details of any third party involved** *(continue on a separate sheet at the end of the form if necessary)*

Documents You Need to Send Us – **SEND ORIGINAL DOCUMENTS BUT KEEP COPIES FOR YOUR RECORDS**

1. The original trip cancellation invoice. If your booking was for a flight only you may not be able to obtain this document, if so, please obtain written confirmation from your airline or travel agent.
2. Original booking invoice, showing date of booking, date of travel and a full breakdown of the trip costs. Please also supply all unused travel tickets, itineraries etc.
3. If cancellation is due to redundancy, we require a letter from your former employer which confirms; you have been made redundant and are due to receive a payment under the current Redundancy Payment Legislation, the position you held and your length of service.
4. If cancellation is on medical grounds, including death, the attached medical certificate must be completed by the usual medical practitioner of the individual whose condition has led to the submission of the claim.
5. If cancellation is due to a death, we also require a **certified copy** of the death certificate. In addition, if the deceased is an insured person under the policy, we require a **copy** of the Grant of Probate issued in respect of the deceased's estate.
6. If the claim is being submitted as a result of an injury please provide a full description of the incident leading to the injury. If a third party was involved please provide their details and those of their insurer, if available.
7. If the claim is for trip abandonment, we require written confirmation from the airline of the delay / cancellation of the flight, the reason for the delay and the length of time the delay lasted.
8. If cancellation is for any other reason, please provide independent written evidence of the incident or circumstances which have resulted in the submission of the claim.

## Other Insurance

**Do you (or anyone else claiming) have any other insurance which may cover this trip. eg Travel insurance with your bank / credit card account, tour operator / travel agent or home contents insurance etc.** *(NB contribution payment is normal practice where 2 policies cover the same loss).*

**Yes** ☐ **No** ☐ *If yes, please supply the following details:*

**Company name and address**

**Policy Number**

**Has a claim been submitted to any other company for this incident:** **Yes** ☐ **No** ☐ *If yes, please provide details:*

## Previous Claims

**Have you made any previous claims on this type of insurance:** **Yes** ☐ **No** ☐ *If yes, please provide details:*
*(continue on separate sheet on page 5 if necessary)*

**Method of payment:** **Cash** ☐ **Cheque** ☐ **Credit / Debit Card** ☐ **Reward points / Airmiles** ☐

**If a Credit / Debit card was used to pay all or some of the trip cost, please state:**

| Name of card supplier | Card type |
|---|---|
| | |
| | |
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| | |
| | |

## Medical Certificate

This **must be** completed by the **Registered General Practitioner** (GP) of the person whose illness / injury / death has given rise to the claim. Any charge made for the completion of this certificate is the responsibility of the insured and is not refundable under the insurance policy. Please ensure the GP answers all relevant questions. Ticks, dashes, N/A etc will not be acceptable. This information will be treated as private and confidential. A certificate not containing the specific information requested will not normally suffice.

**Full name of patient** **Date of Birth** / /

**Are you the regular medical attendant / from the same practice:** Yes No **If yes, for how long**

**If no, what is your involvement with this matter**

**State precise nature of the medical condition / illness / injury / cause of death, that gives rise to this claim**

**If injury, state how this was caused**

**If claim is result of pregnancy:** **Date pregnancy confirmed** / / **LMP** / / **EDC** / /

**Has patient suffered from the same or related condition in the past five years:** Yes No **If yes, for how long**

**State the exact date of onset of symptoms of conditions** / / **Date first consulted** / /

**Date of any serious deterioration / exacerbation, if applicable** / /

**What ongoing medical condition(s), or medical complication directly attributable to the condition(s), were being investigated by a registered medical practitioner at:**
**Date trip insurance was purchased** / / **Date trip was booked** / /

**Is the illness / injury attributable to drugs, alcohol or HIV or HIV related illness, including AIDS:** Yes No

**Give details**

**Has the person named above received a terminal prognosis:** Yes No

**If yes, what date was the terminal prognosis given to:** **The patient** / / **The claimant** / /
*(if not the same person)*

**Has the patient been referred to or seen by a hospital doctor or surgeon or needed inpatient treatment for this or any related condition within 12 months prior to the date the trip insurance was purchased? If so, please give full details including dates:**

**If the patient was booked to travel did they consult you prior to booking or travelling regarding the advisability of undertaking the holiday or journey:**

Yes No **If yes, on what date** / /

**If no, when would you have advised cancellation had you been aware of the planned trip**

**If the patient travelled, were they fit to travel the date of departure**

**Provide details of patient's state of health at the time the insurance was purchased and date of booking the trip**

**State exact reason for cancellation**

**Please advise the date when it first became apparent that the holiday should be cancelled** / /

**Please state the exact date you advised the need to cancel** / /

**Are you prepared to certify that, soley due to the condition described above, the claimants are compelled to cancel their holiday arrangements:**

Yes No

**To be completed by the usual Registered General Practitioner (GP):** I have examined the patient and / or referred his / her medical records and I declare that the information given is correct and that no details relevant to the case have been omitted.

**Name** **Qualifications**

**Sign** **Date** / /

Surgery Stamp

## Bank Details

**Should Auto & General Insurance Company Limited need to reimburse you we require your bank details.**

**Name of Account Holder**

**BSB**

**Account Number**

## Additional space to continue any questions necessary