

Claimant's Name

## **Cutting Your Trip Short and Additional Emergency Expenses**

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.

your claim, and send by re	gistered post	to ensure del	ivery.											
Claimant Details				Claim	Refe	ence (if I	know	rn)						
Title (Mr / Mrs etc) First Name				Sı	urnam	•					Date o	of Birth	1	
														/
Nationality				Occupati	on									<i>'</i>
Medicare Number				Parent / Guardian's Medicare Number (If medical claim is for a minor)										
Home Address				Home Ph	one									
				Work Pho	one									
				Mobile										
State	Postco	ode		Email										
Policy Details														
Policy Number				Date Issu	ed	/	/	,	Numbe	r of Tr	avellers			
Independent Travel Arrange	ments:	Yes	No No	If no. pro	∟_ vide th	e following	7*:							
				•										
*Travel Agent and Branch				*Tour Op	erator									
Date of Booking		Departure Date			F	eturn Date	e		1	Tot	tal Days			
/ /		/	/			/		/						
Country	,			— Resort / T	Town				-					
I DECLARE THAT:  I will use my best endeavours at Auto & General Insurance Com The information supplied by me information likely to affect the a I understand that the claim may have not revealed all relevant fa I understand that by investigatin General Insurance Company Lin any of its rights in defence of ar A photocopy of this Authorisation original and I specifically author appoint Auto & General Insurance expedient to: give effect to the transactions of execute and deliver any other ditransactions described. I authorise any person, corporation whether named by me or not, to If you wish to give authority be able to give any informat I / We, authorise (Name)	pany Limited in to it is true and common to it is true and common to be denied if the cts; ig my claim or by mited has made by claim arising upon shall be consise its use as succe Company Limum tontemplated by ocuments or do on, institution, priprovide such inferfor another p	he assessment of ect and I have not y claim; information suppl accepting proofs no acceptance of nder the policy; dered as effective hited to do everythithe authorisations any other acts refevate or government or mation as Auto & erson to act on	my claim: withheld any ied is untrue, of my claim, liability, nor vand valid as tong necessary described; a erred to in the organisation General Insupur beha	or I  Auto & vaived P  he T  or V  nd a a e  on, ourance  If in respect	angoing all med receive my He any infraceive or any infraceive or	benefits or i ical, surgical d by me and proper and the incompa- promation fro benefit, or r tatement onal and sen ovide in con a, compile ar nave to discl and process advisors, sei to third part where you m us at budget	my cla or oth any me clain relation m thirm my enti- sitive in nection d anal ose you sing the rvice poties in t ay requidirect@	im including, ner informatic nedication tal ns history, inc n to my asset d persons whitement to re nformation c on with this cl lyse data, and sur personal a is claim, incl. is claim, incl. is claim, incl. incroviders, or a the countries uire assistanc aclaims-trave		myself, myself, ed for it re; nings, s, s, formati form, s, d, d, s, ed form, s, d, ed form, s, d, ed form, s, d, ed form, s, ed formation for for formation for for formation for for formation for for formation for f	my med me (at any calary or v on releva nefit and other and discles. to third p lealth pro ir persona ed under tion pleas	vages (at informa osed by arties which informa osed by arties which information information information information information information information information information information informatio	t any tir deligibil detion year designation n dicy, or ur priva	r treatment me); lity to ou or third process st us in ators, our nay also be any other acy policy
of (Address)										P	ostcode			
Phone			Mobile						Date o	f Birth	1		/	/
I have read and fully understa	nd the declarat		•	aiming must	sign)		_				_			
Claimant's Name		Sig	nature				Da	te of Birth		_	Date			

Date of Birth

Signature

Curtailment Details						
Date of scheduled return / / Number of days booked						
Actual return date / / / Number of days unused						
If your trip was shortened due to a person who was not travelling with you, please state their name and relationsl	nip to you:					
Name Relationship						
Was any attempt made to revalidate or use your original tickets: Yes No						
If yes, were you successful in your attempts:						
If no, please provide an explanation as to why no attempt was made to revalidate your tickets (continue on a sepa	rate sheet at the end of t	he form if necessary)				
Names and ages of all those shortening their trip:						
Name	Date of Birth	/ /				
Name	Date of Birth	/ /				
Name	Date of Birth	/ /				
Name	Date of Birth	/ /				
Name	Date of Birth	/ /				
Name	Date of Birth	/ /				
Did you contact Budget Direct: Yes No If no, please explain below: (continue on a separate sheet at the end of the form if necessary)						
First call: Date / / Time AM PM						
Name of person spoken to Reference No						
Please detail the reasons for shortening the trip (continue on a separate sheet at the end of the form if necessary)						
Please list each receipt / bill separately in the table below. Claims will be converted to Australian dollars using the currency rate applicable at the date and time the expenses were incurred.						
Date of Description of Evpons Amount Date of Description	ation of Original Cost	Amount				

Date of Expense	Description of Expense	Amount	Date of Original Plan	Description of Original Cost	Amount
e.g. 24/07/07	e.g. Hotel in Paris	e.g. EUR 100	e.g. 24/07/07	e.g. Flight to Munich	e.g. EUR 75

## Documents You Need to Send Us - SEND ORIGINAL DOCUMENTS BUT KEEP COPIES FOR YOUR RECORDS

- 1. Original evidence to show your dates of outward and return travel, eg booking invoice, travel tickets, itinerary etc. and a full breakdown of the total holiday cost.
- 2. All unused and used travel tickets, itineraries etc.
- 3. Original evidence of all additional travel expenses.
- 4. If the trip is cut short due to a medical condition, including death of someone, the attached medical certific te should be completed by the usual GP of the individual whose condition has caused the submission of this claim.
- 5. If shortening the trip was due to injury or illness of a person travelling on the trip, please provide written confirm tion from the relevant overseas physician to confirm the medical necessity of the trip being shortened.
- 6. If trip being shortened is due to a death, we require a certified copy f the death certific te. In addition, if the deceased was an insured person, we require a copy of the Grant of Probate of Letters of Administration issued in respect of the deceased's estate.
- 7. If this 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.
- 8. If the trip being shortened is for a reason other than those detailed in points 4 and 5 please forward independent written evidence of the incident or circumstances.

If you are unable to supply any of the documentation requested please provide a written explanation as to why.

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 No	f yes, please provide details:			
Method of payment for the trip: 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:	I				
Name of card supplier			Card type			
Bank Details						
Should Auto & General Insurance Company Limite	d need to reimburse you we	require your bank details.				
Name of Account Holder						
BSB	Account Number					
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 (i.e. a full entitlement is 100%)	entitlement percentage:			

Additional space to continue any questions necessary					