

Claimant's Name

Medical Emergency and Associated 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

Claimant Details		Cla	im Referei	nce (if kno	wn)					
Title (Mr / Mrs etc)	First Name		Surname				D	ate of	Birth	
									/	/
Nationality		Occi	upation						/	/
rationalty			аралоп							
Medicare Number			nt / Guardian's edical claim is							
Home Address		Hom	ne Phone							
		34 6 m mil	l. Di							
		wor	k Phone							
		Mob	ile							
State	Postcode	Ema	il							
Policy Details										
Policy Number		Date	Issued	/	/	Number	of Trave	llers		
Indonesia desta Trascal Arrena	vomante: Vas	No. If no	, provide the f	allawina*:	-			L		
Independent Travel Arrang	gements: Yes			Silowing".						
*Travel Agent and Branch		*Tou	ır Operator							
Date of Booking	Departure Da	ate	Ret	urn Date	,		Total I	Days		
/ /		/		/						
Country		Reso	ort / Town							
Auto & General Insurance Co The information supplied by rinformation likely to affect the I understand that the claim m have not revealed all relevant I understand that by investiga General Insurance Company any of its rights in defence of A photocopy of this Authorisa original and I specifically auth I appoint Auto & General Insura expedient to: give effect to the transactions execute and deliver any other transactions described. I authorise any person, corpora whether named by me or not, t If you wish to give authori be able to give any inform I / We, authorise (Name)	ay be denied if the information surfacts; ting my claim or by accepting pro Limited has made no acceptance any claim arising under the policy; ation shall be considered as effecti	of my claim: not withheld any pplied is untrue, or I ofs of my claim, Auto & of liability, nor waived we and valid as the withing necessary or ons described; and referred to in the nent organisation, o & General Insurance on your behalf in re	ongoing bei all medica received b my Health any inform any inform receive be Privacy Stat The persona parties prov this claim, c We may hav assessing ar specialist ad disclosed to regions whe or email us a	nefits or my c I, surgical or c yo me and any In Insurance cla- nation in relati- nation from the ment all and sensitive de in connect ompile and ar- re to disclose your disclose of diprocessing visors, service third parties in ere you may re- at budgetdirect	claim includir ther information in medication aims history, on to my assird persons on titlement to be information with this halyse data, a your personal this claim, in providers, on the countracture assistated.		on: yself, my yself, my f for me (f; ngs, salar rmation r g benefit orm, and used anc sputes. attication to t ers, healt f. Your pe ninated L ormation g details	medica (at any ti y or wag relevant other in d disclos hird part h provicersonal in under you n please	Il history, me); ges (at ar to my eli formatio ed by us ties who lers, inve nformatio ur policy see our p	any treatmer ny time); gibility to n you or thirc to process assist us in stigators, our on may also b t, or any other
of (Address)							Post	code		
Phone		Mobile				Date of	Birth		/	/
•	tand the declarations above (A		must sign)				_			
Claimant's Name	9	Signature		D	ate of Birt	n	Da	ate		

Signature

Date of Birth

	/ /		□ AN	M			
Injury Occurrence: Date	/ /	Time	□ PA				
Country and town where ill	lness or injury occur	red					
Full description of illness o	r injury and details o	f any third party i	nvolved				
Have you previously suffere	ed from the conditio	n which has resul	ted in the submi	ssion of this claim	, or any related	d condition:	
No If yes, we may require your GP to complete a medical certificate							
Yes No	If yes, we may rec	quire your GP to co	отріете а теаіса	al certificate			
	Date of admittance			Time	□ AM □ PM		
Yes No No If you were an inpatient:			/ 1	Time			
	Date of admittance	/	/ 1	Time Time	□ PM □ AM □ PM	ance:	
If you were an inpatient:	Date of admittance Date of discharge an outpatient and ex	xpenses exceeded	/ 1 \$500 did you co	Time Time	□ PM □ AM □ PM ergency assist		
If you were an inpatient:	Date of admittance Date of discharge an outpatient and existing the second (please use separation).	xpenses exceeded	/ 1 \$500 did you co	Time Time ontact medical em	□ PM □ AM □ PM ergency assist		

Name of Doctor / Dentist / Pharmacy / Hospital or Provider	Treatment Performed	Date of Treatment	Amount Charged (State Currency)	Paid Yes / No	Refund from Health Funds
e.g. Doctor R Smith	e.g. Consultation	e.g. 10/02/07	e.g. EUR 100	e.g. Yes	e.g. EUR 75

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

- 1. Original evidence to show dates of outward and return travel (booking invoice, travel tickets, itinerary etc.)
- 2. All original invoices / receipts for expenses incurred.
- 3. If claim is submitted on behalf of the estate of a deceased insured, we will require certified copies of the death certificate, together with Grant of Probate or Letters of Administration. If the insured passed away due to illness rather than as a result of injury, we may require a medical certificate to be completed by the deceased's usual GP.
- 4. If this claim is being submitted as a result of 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.

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

Important - Please number all receipts for expenses incurred or pre-loss supporting documentation and put the number in the column headed 'Receipt No.' when completing the 'Medical Expenses' section above.

Other Insurance		
Do you (or anyone else claiming) have any other insurance which may cover this trip. eg Travel insurance with your bank / creditavel agent or home contents insurance etc. (NB contribution payment is normal practice where 2 policies cover the same loss).		our operator /
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:	
Health Conditions		
At the date of travel, purchase of the policy or booking your trip, were you or the person whose condition has given rise to the		
Aware of any medical condition or set of circumstances which could reasonably be expected to give rise to a claim Have an on-going medical condition (or any medical complication directly attributable to that condition) which was being	Yes	No
investigated by a specialist or GP (if the condition was declared at purchase of the policy, please give details below)	Yes	No
Have a medical condition directly or indirectly related to the condition for which the claim is being made (if the condition was declared at purchase of the policy, please give details below)	Yes	No
Received or were awaiting hospital tests or treatment for any condition or set of symptoms which had not been diagnosed	Yes	No
Had been given a terminal prognosis	Yes	No
Were travelling for the purpose of obtaining medical treatment abroad	Yes	No
Were travelling against the advice of a medical practitioner	Yes	No
Had received or were awaiting treatment relating to a complication of pregnancy or childbirth	Yes	No
Were more than 32 weeks pregnant at the start of or during your trip	Yes	No
Was a letter concerning any of the above obtained from the treating doctor (if yes, please forward a copy of the letter)	Yes	No
If yes was answered to any of the above, please give further details of the condition or circumstances (Please note that we may need your GP to complete a medical certificate)		
Are you expecting to receive or are you going to submit any further accounts: Yes No If yes	, please provide d	letails
(continue on separate sheet at the end of the form if necessary)		Cians

If you require us to make a direct payment for medical costs, and your policy is subject to an excess, this must be paid before we can do so. Please enclose a cheque made out to Auto & General Insurance Company Limited or contact us to arrange payment by credit / debit card. If you have paid all costs, please enclose all receipts. Payment of acceptable expenses would normally be made to the claimant. If you require payment to be made to another person, please forward their details and provide your written permission for us to do so.

Account Number GST (for domestic policy claims only) re you registered for GST and did you claim a Yes No If yes, what is your input tax credit entitlement percentage:	Bank Details								
Account Number GST (for domestic policy claims only) re you registered for GST and did you claim a ST input tax credit on your premium? No If yes, what is your input tax credit entitlement percentage: (i.e. a full entitlement is 100%)	Should Auto & General Insurance Company Limited need to reimburse you we require your bank details.								
GST (for domestic policy claims only) re you registered for GST and did you claim a ST input tax credit on your premium? No If yes, what is your input tax credit entitlement percentage: (i.e. a full entitlement is 100%)	Name of Account Holder								
re you registered for GST and did you claim a Yes No If yes, what is your input tax credit entitlement percentage: (i.e. a full entitlement is 100%)	BSB	Account Number							
ST input tax credit on your premium? (i.e. a full entitlement is 100%)	GST (for domestic policy claims only)								
Additional space to continue any questions necessary	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%)							
	Additional space to continue any que	estions necessary							
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M	adi	cal	Cer	tific	ata

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 LMP **EDC** If claim is result of pregnancy: Date pregnancy confirmed If yes, for how long Has patient suffered from the same or related condition in the past five years 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 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: 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 Qualific tions Surgery Stamp Sign Date