Budget Direct
simply smarter insurance®

Travel Insurance Claim Form

# 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 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**

## Medical Emergency and Associated Expenses

**Injury Occurrence: Date** / / **Time** ☐ AM ☐ PM

**Country and town where illness or injury occurred**

**Full description of illness or injury and details of any third party involved**

**Have you previously suffered from the condition which has resulted in the submission of this claim, or any related condition:**

**Yes** ☐ **No** ☐ *If yes, we may require your GP to complete a medical certificate*

**If you were an inpatient: Date of admittance** / / **Time** ☐ AM ☐ PM

**Date of discharge** / / **Time** ☐ AM ☐ PM

**If you were an inpatient or an outpatient and expenses exceeded $500 did you contact medical emergency assistance:**

**Yes** ☐ **No** ☐ *If yes, please complete the fields below. If no, please provide a written explanation as to why not (please use separate sheet at the end of the form).*

**Date of first call** / / **Person spoken to**

**Reference No**

## Medical Emergency and Associated Expenses *(Please list all expenses and continue on separate sheet at the end of the form if necessary)*

| Receipt number | Date | Description of item | Bill from | Amount | Currency | Exchange rate | Amount | Paid Y/N |
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| | | | | | | | **Total Claimed** | |

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 / 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

**Has a claim been submitted to any other company for this incident:** **Yes** ☐ **No** ☐ *If yes, please provide details:*
*(continue on separate sheet on page 4 if necessary)*

## 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 claim:**

| | | |
|---|---|---|
| **Aware of any medical condition or set of circumstances which could reasonably be expected to give rise to a claim** | **Yes** ☐ | **No** ☐ |
| **Have an on-going medical condition (or any medical complication directly attributable to that condition) which was being 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 details*
*(continue on separate sheet at the end of the form if necessary)*

**Important Notes:**
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.

## 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

## 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