



**TRAVEL INSURANCE CLAIM FORM**

The issue and acceptance of this form does not constitute an admission of liability by the Underwriters or their agents.

On completion of this claim form please return it and relevant supporting information to:

Steley CAP  
 PO Box 5344  
 Brendale Qld 4500  
 AUSTRALIA

Please ensure the following documentation (as a minimum) is appended to your claim form.

**Medical Expenses claim:**

- 1. Receipts / invoices for costs incurred
- 2. Unused tickets / accommodation vouchers

**Travel Delay claim:**

- 1. Statement from carrier confirming delay / reason / duration
- 2. Receipts for additional travel / accommodation costs

**Personal Property claim:**

- 1. Written report from police or similar
- 2. Proof of ownership / value documentation.
- 3. Repairer's report (if item has been damaged)
- 4. Property Irregularity Report (if applicable)

**Cancellation claim:**

- 1. Medical Certificate (refer Steley CAP if required)
- 2. Death Certificate (if applicable)
- 3. Unused / cancelled travel / accommodation vouchers
- 4. Evidence of refund/s from airline / hotels etc

POLICY INFORMATION		
Name	Date of Birth	Certificate No.
Address		Post Code
Telephone (w)	(h)	(m)
Email		
Employer		Occupation
Have you made any travel insurance claims in the past 3 years?		Yes / No
If yes, please provide full details		

CANCELLATION / LOSS OF DEPOSIT / CURTAILMENT			
Please detail the reason you could not commence or complete your proposed journey			
Date your trip was cancelled / curtailed			
Scheduled Departure Date		Scheduled Return Date	
Total Amount of Deposit Paid		Date Paid	
Total Amount of Balance Paid		Date Paid	
Total Amount Refunded		Date Refunded	
Total Amount Claimed		Date Insurance Purchased	
Description of Curtailment (post-departure) Expenses incurred			
Date	Nature of Expense	Name & address of hotel or similar	Cost (+ currency)

**TRAVEL DELAY / MISSED CONNECTIONS**

Please explain the reason your travel was disrupted

Scheduled Date/Time of Departure

Flight No or similar

Actual Date / Time of Departure

Flight No or similar

Number of hours delayed

Amount claimed

**MEDICAL / DENTAL EXPENSES**

Date of injury / illness / death

Time

am / pm

Location where injury/illness sustained

State exact nature of illness / injury

Please provide a detailed account of circumstances in which the illness / injury was sustained:

Have you previously suffered from the same or similar condition?

Yes / No

If yes, please provide details including date of most recent occurrence

Name, address and contact details for usual doctor / dentist

Do you have private health insurance?

Yes / No

If yes, please provide policy details

Name and address for doctor who treated you abroad

Date of Treatment: From

To

If hospitalised: Date of Admission

Date of Discharge

Name &amp; address of hospital

Are you able to claim any costs incurred from your private health fund?

Yes / No

Have you paid all medical / additional travel costs?

Yes / No

Were you suffering from or receiving treatment for this condition prior to departure?

Yes / No

If yes, please provide details

Did you return home on your scheduled date?

Yes / No

Did you call the 24 hour Medical Assistance service?

Yes / No

If yes, please advise when and to whom you spoke and detail advice given

**Description of Medical Expenses incurred (if insufficient space please attach separate sheet)**

Date	Nature of Expense	Name & address of Hospital or medical practice	Cost (+ currency)

**Description of Additional Travel Expenses incurred**

Date	Nature of Expense	Name & address of hotel or similar	Cost (+ currency)

**PERSONAL PROPERTY LOSS OR DAMAGE**

Date of loss or damage	Time	am / pm
Where did loss or damage occur?		
Detail of police / airline / tour operator etc to whom reported		
Date and time reported to police / airline or similar	Time	am / pm
If no report obtained, please advise reason		
Details of steps taken to minimise loss or recover property		
Please provide a detailed account of how loss or damage occurred		
Have you received compensation from another source?	Yes / No	Amount?
Is any of the property lost or damaged insured by another company?	Yes / No	
If yes, please provide details of company involved and amount received		
Do you consider any other person responsible for causing the loss / damage?	Yes / No	
If yes, please provide full details including reason		
Are there any witnesses to the loss / damage?	Yes / No	
If yes, please provide full details including contact information		

**Please provide full details of claimed items and complete each column (use separate sheet if required)**

Full description of property inc model / serial number if applicable	Owned by?	Original cost price	Date of purchase	Amount claimed after application of depreciation	Proof of ownership / value attached
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No
					Yes / No

**RENTAL VEHICLE EXCESS WAIVER****Please attach Hire Agreement, itemised repair invoice & evidence of excess charged by hire company**

Date of accident / damage	Time	am / pm
Please provide full account of circumstances of the accident / damage		
Had the driver consumed liquor / drugs in the 24 hours preceding the accident?	Yes / No	
Did you organise insurance or pay excess reduction fees at the time of vehicle collection?	Yes / No	
Do you consider any other party responsible for the damage?	Yes / No	
If yes, please provide details		

**MISCELLANEOUS CLAIMS**

If you are claiming under a section of the policy for which there is no provision on this claim form, please provide full details of your claim below. Please attach a separate sheet if there is insufficient space.


**PREFERRED SETTLEMENT OPTION**

In the event your policy can respond to your claim, please indicate your preferred method of settlement.

Cheque to your postal address

Direct Credit to your bank account

Name of Bank:

BSB:

Account No:

Account Name:

**DECLARATION**

I / we hereby declare:

1. All the information stated on this claim form and supplementary statements made in relation to my / our claim/s are true and complete.
2. I / we have not withheld any information which is relevant to this claim/s.
3. I / we have appended all documentation noted on the facing sheet of this claim form and any additional information requested of me/us by the Underwriters and/or their agents.
4. I / we undertake to provide any other information which the Underwriters or their agents deem necessary for the assessment of my / our claim.
5. I / we have read and understand the following Privacy Notice and consent to the collection and use of my / our personal information as allowed by law.

Claimant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Claimant's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**General Insurance Information Privacy Wording**

Lloyd's and its agents are bound by the obligations of the Privacy Act 1998 as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act). This sets out basic standards relating to the collection, use, disclosure and handling of personal information.

"Personal Information" is essentially information or an opinion about a living individual whose identity is apparent or can reasonably be ascertained from the information or opinion. Information will be obtained from individuals directly where possible. Sometimes it may be collected indirectly (e.g. from your representatives).

Only information necessary for the arrangement and administration of Lloyd's business by Lloyd's, its agents and their representatives will be collected. This includes information necessary to accept the risk, to assess a claim, to determine competitive and appropriate premiums etc.

Lloyd's and its agents disclose personal information to third parties who they believe are necessary to assist them in doing the above. These parties will only use the personal information for the purposes we provided it to them for (or if required by law).

When you give Lloyd's and its agents personal information about individuals, we rely on you to have made or make them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information if you wish and request correction if required.

Lloyd's and its agents comply with the general insurance Code of Practice. You can access the Code of Practice via the Insurance Council of Australia website or [www.codeofpractice.com.au](http://www.codeofpractice.com.au)



**MEDICAL CERTIFICATE – CANCELLATION / CURTAILMENT CLAIMS**

This document is to be completed by the usual doctor of the person whose state of health, injury or death has given rise to a cancellation / curtailment claim. **(NOTE: This form does not need to be completed for Medical Expenses claims).** Any charges or fees raised for the completion of this form must be paid by the claimant. This document, when completed, must be stamped by the relevant practitioner to ensure authenticity. Faxed copies will not be accepted.

**IMPORTANT NOTE TO DOCTOR**  
 We respectfully request that you give as much detail as possible in order to assist with the assessment of the claim and to avoid the necessity of additional enquiries.

**POLICY INFORMATION**

Name of Claimant	Certificate No.
Address	Post Code

**PATIENT DETAILS**

Full Name		
Address		
Relationship to Claimant (if applicable)		
Date of Birth	Date of Death (if applicable)	
Are you the patient's usual practitioner?	Yes / No	If yes, how long?
Please advise precise details of the illness/injury which has given rise to the claim?		
What was the date of onset of the illness or the date injuries were sustained?		
What was the date you were first consulted in relation to the illness / injury?		
Is the condition caused by or traceable to any recurring or chronic illness / condition?	Yes / No	
If yes, please provide full details of related condition/s and treatment provided		
Has the patient suffered from the same or similar condition?	Yes / No	
If yes, please provide full history		
Has the patient been awaiting/receiving tests, investigations, treatment, referral for this condition?	Yes / No	
If yes, please provide full details including relevant dates		
Has the patient been receiving any medication?	Yes / No	
If yes, please provide full details including drug name/s and dosage/s		
In the event of pregnancy please state: 1) The EDD	2) The LMP	
Has there been a complication in the current / previous pregnancy?	Yes / No	
If yes, please provide full details		
Do you consider the patient (if claimant) would have been fit to travel as planned?	Yes / No	
Did you advise the patient (if claimant) to cancel / curtail the planned journey?	Yes / No	

Signed: \_\_\_\_\_

Date: \_\_\_\_\_

Name: \_\_\_\_\_

Position: \_\_\_\_\_