

You must register any claim within 30 days after completion of your travel. You need to supply to us original documents of the evidence you intend to rely upon in your claim, by registered post to ensure delivery.

Claimant Details		Claim Reference (if known)	
Title (Mr/Mrs etc)	Surname	Forename(s)	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 in Party	
	/ /		
Independent Travel Arrangements: Yes <input type="checkbox"/> No <input type="checkbox"/>	If no, provide the following *:		
*Travel Agent & Branch	*Tour Operator		
Date of Booking	Departure Date	Return Date	Total Days
/ /	/ /	/ /	
Country	Resort/Town		

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 by the use of legal action.

I/We hereby declare that:

1. All information and documents submitted for this claim are true and correct.

2. Information on this form will be used by Mapfre Insurance Services Australia Pty Ltd (Tick Travel Insurance) for my insurance which includes underwriting, claims handling, fraud prevention and could include passing to other insurers to access my previous claims history.

3. We subrogate rights of recovery to Mapfre Insurance Services Australia Pty Ltd (Tick Travel Insurance) and also consent to them seeking reimbursement of any medical expenses paid by them.

For medical related claims:

4. This is an Authority by me for any doctor, hospital, insurer, other organisation or person having any records or information concerning my medical history/treatment to furnish records/information as may be requested by Mapfre Insurance Services Australia Pty Ltd (Tick Travel Insurance) or their agents. 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.

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

Privacy Statement & Consent

☐ **I have read, understood and agree with the Privacy Statement below**

The personal and sensitive information collected in this form and other information you or third parties provide in connection with this claim will be collected, held, used and disclosed by us to process this claim, compile and analyse data, and resolve claim disputes. If you do not provide this information to us we may not be able to process this claim.

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 service providers, investigators, our specialist advisors, our service providers, or as required or authorised by law.

Your personal information may be disclosed to entities and parties located overseas, including Spain, United Kingdom and the Philippines. Your personal information may also be disclosed to entities and parties in the countries and regions nominated under your insurance policy, or any other regions where you may require assistance.

You have the right to seek access to your personal information and to correct it at any time. For information about how you may access and request correction of personal information we hold about you, or complain about a breach of the Australian Privacy Principles, please see our privacy policy available at www.tickinsurance.com.au/privacy-policy.html or contact us at info@tickinsurance.com.au.

Claimant's Name	Signature	Date of Birth	Date
		/ /	/ /
Claimant's Name	Signature	Date of Birth	Date
		/ /	/ /

Medical Emergency and Associated Expenses

Injury Occurrence: Date	/	/	Time	AM PM
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Country and town where illness 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	<i>If yes, we may require your GP to complete a medical certificate</i>
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If you were an inpatient: Date of admittance	/	/	Time	AM PM
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Date of discharge	/ /	Time	AM PM
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If you were an inpatient or an outpatient and expenses exceeded \$500 did you contact the medical emergency assistance company:

Yes	No	<i>If yes, please complete the fields below, if no, please provide a written explanation as to why not (a separate sheet at the end of the form is provided for written explanation)</i>
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Date of first call	/	/	Person spoken to	
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Reference No	Author	Year	Journal	Volume	Issue	Page
1	Smith, J.	2015	Journal of Management	42	3	567-589
2	Johnson, A.	2016	Journal of Marketing	50	1	123-145
3	Williams, B.	2017	Journal of Finance	72	2	345-367
4	Brown, C.	2018	Journal of Economics	115	4	789-812
5	Green, D.	2019	Journal of Law and Economics	62	1	234-256
6	White, E.	2020	Journal of Business	93	3	456-478
7	Black, F.	2021	Journal of Accounting	48	2	567-589
8	Gray, G.	2022	Journal of Information Systems	45	1	123-145
9	King, H.	2023	Journal of Operations Management	41	3	567-589
10	Lee, I.	2024	Journal of Strategic Management	47	2	345-367

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
							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 Insurances

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 (A 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

Previous Claims

Has a claim been submitted to any other company for this incident: Yes ☐ No ☐

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 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:

Yes ☐

No ☐

(if the condition was declared at purchase of the policy, please give details below)

Have a medical condition directly or indirectly related to the condition for which the claim is being made:

Yes ☐

No ☐

(if the condition was declared at purchase of the policy, please give details below)

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 you 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:

Yes ☐

No ☐

(if yes, please forward a copy of the letter)

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 direct payment of the medical costs and your policy is subject to an excess, this must be paid before we can do so. Please enclose your remittance in favour of Mapfre Insurance Services Australia Pty Ltd (Tick Travel Insurance Australia) or contact us to arrange payment by credit/debit card. If you have paid all costs, please enclose all receipts. Payment of admissible expenses would normally be made in favour of the claimant. If you require payment to be made in favour of another person, please forward their details and provide your written permission for us to do so.

Bank Details

Should Tick Travel Insurance need to reimburse you we require your bank details as follows:

Name of Account Holder

BSB

Account number

Separate sheet to continue any questions necessary