TICK Travel Insurance

Travel Insurance Claim Form | Loss of Income

You must register any claim within 30 days after completion of your travel. We prefer if you lodge your claim with us digitally, either through our Tick Website (https://quote.tickinsurance.com.au/policylogin.aspx) or emailing us a scanned copy of this claim form along with a copy of documents requested.

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 ☐ No ☐ *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 Europ Assistance 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 Europ Assistance 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 Europ Assistance 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

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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 / /

This **must be** completed by the injured person's employer, or if self employed, by an accountant. This form is to verify the loss of income of a person whose illness/injury/death has given rise to the claim. Any charge made for the completion of this form is the responsibility of the insured and is not refundable under the insurance policy. Please ensure the employer answers all relevant questions. Ticks, dashes, N/A etc will not be acceptable. This information will be treated as private and confidential.

Employee Details

Title *(Mr/Mrs etc)* | Surname | Forename(s) | Date of Birth

Home Address

☏ Home Phone

☏ Work Phone

☏ Mobile

State | Postcode

✉ Email

Employment Details *(as at date of incident)*

If the injured person was self employed you do not have to complete this section. Go to 'Employer or Accountant details' below.

Place of employment | Date employment commenced | Date employment would have ceased

Description of duties

Employee's normal working hours *(include regular and continuing overtime)*

Days per week | Hours per day | Usual start time ☐ AM ☐ PM | Usual finish time ☐ AM ☐ PM

If the employee worked regular overtime, would it have continued if there had not been an accident? Yes ☐ No ☐
if yes, please provide details

Employer or Accountant Details

If the injured person was self employed you need to complete this section.

Name/organisation/company name | ABN/ACN

Address

☏ Phone

✉ Email

What is the nature of the business

Is the employee related to the employer? Yes ☐ No ☐ *if yes, please provide details*

Wage Details

What were the weekly earnings including overtime, regular bonuses, commission of the employee (paid on a regular basis) before the incident

Gross normal earnings | Gross overtime earnings | Other gross earnings

Total gross earnings | Less tax | Total net earnings

What award did the employee work under: Federal ☐ State ☐

Details of Absences as a Result of The Accident

On what dates was the employee absent from work due to the accident

Work time lost (weeks / days / hours)	Date From	Date To
	/ /	/ /
	/ /	/ /
	/ /	/ /
	/ /	/ /

Has the employee returned to work: Yes ☐ No ☐ If no, will the position be held open: Yes ☐ No ☐

If payments have been made give details below *(eg sick pay, workers compensation)*

Details of payment / amount

Details of person completing this form *(Employer or Accountant)*

Name

Position in business

☏ Home

☏ Mobile

☏ Work

✉ Email

Signature

Date / /

Bank Details of Claimant

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

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