TICK Travel Insurance

Travel Insurance Claim Form | Medical Emergency and Associated Expenses

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 ☐ 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 / /

Medical Emergency and Associated Expenses

Injury Occurrence: Date / / Time ☐AM ☐PM

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 ☐ *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 the medical emergency assistance company:

Yes ☐ No ☐ *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)*

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
							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: *(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 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: *(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 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 Europ Assistance 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

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