

BAGGAGE CLAIM

Date of incident / Time am pm

Date discovered / Time am pm

Place where loss, theft or damage occurred

To whom was the incident reported

Police Yes No Date / Time am pm

Carrier Yes No Date / Time am pm

Other Yes No Date / Time am pm

You must attach the original reports given to you. If you do not have a report please advise why.

DETAILS OF LOSS OF BAGGAGE

Proof of value and ownership in the form of purchase receipts, valuation certificates obtained prior to the loss, guarantee cards and instruction booklets MUST be included.

Description of property lost, destroyed or damaged	Date of purchase	Original price paid	From whom purchased	Office use only
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text" value="/"/> / <input type="text" value="/"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Continue on a separate sheet if necessary		Total \$	<input type="text"/>	<input type="text"/>

CANCELLATION CHARGES

You must provide documentation from the tour operator, carrier and travel agent verifying the cancellation charges imposed by them.

Name of person causing cancellation Date of birth /

Relationship to person cancelling

Reason for cancelling (death, illness etc)

Date of incident / Date holiday/journey cancelled /

Names of all who are cancelling

Total cost of holiday (excluding insurance)

Total amount refunded by tour operator/carrier

Total amount of claim

The medical certificate on page 4 of this form must be completed in cases of cancellation arising from death, illness or injury. In the event of a death a copy of the death certificate will be required. You must include independent evidence to support your claim if from any other insured cause.

ADDITIONAL EXPENSES

Please attach receipts for all additional expenditure incurred.

Medical certificate: If additional expenses were incurred because of medical reasons the medical certificate on page 4 must be completed by the usual doctor (GP) of the person whose state of health/injury caused you to incur the additional expenses.

Relationship to you of the person whose state of health caused you to incur the additional expenses

List of expenditure for which reimbursement is required	Amount claimed
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

MEDICAL EXPENSES

Name of ill/injured person Date of birth / /

Relationship to insured

Nature of illness/injury

Did you contact our 24-hour assistance service Yes No If Yes, date / /

Has the ill/injured person suffered from the same or similar illness/injury before? Yes No

If Yes, please give details including dates

Was a doctor consulted at the time of booking the holiday? Yes No

Did he/she consider the ill/injured person fit to travel? Yes No

Name and address of ill/injured person's usual doctor

Name and address of doctor who treated illness/injury abroad

If admitted to hospital

Date admitted / / Time am pm

Date discharged / / Time am pm

Date of expenses	Name of Dr, clinic or other authority who issued receipts/invoices	Cost incurred (state currency)	Paid by yourself	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/>	No <input type="checkbox"/>

(Continue on a separate sheet if necessary)

Except in the case of minor illness or injury the medical certificate on page 4 will be required. We must ask you to note that where this is not completed we reserve the right to require its completion at a later date. In the event of death a copy of the death certificate will be required. If the claim is for repatriation or curtailment of your journey you should include the medical certificate issued by the doctor abroad confirming the necessity of this.

MEDICAL CERTIFICATE

To be completed by the usual doctor (GP) of the person whose state of health/injury has caused you to make this claim.

Name of patient	<input type="text"/>	Date of birth	<input type="text"/> / <input type="text"/> / <input type="text"/>
Are you his/her usual GP?	<input type="text"/>	For how long	<input type="text"/>
Please provide precise diagnosis of the illness/injury	<input type="text"/> <input type="text"/>		
Date of onset of illness/injury	<input type="text"/> / <input type="text"/> / <input type="text"/>	Date on which you were first consulted	<input type="text"/> / <input type="text"/> / <input type="text"/>
Name and address of specialist/surgeon	<input type="text"/>		
Is the described condition caused, accelerated or traceable to any recurring illness or condition?			Yes <input type="checkbox"/> No <input type="checkbox"/>
If Yes, please confirm dates of consultations regarding the condition and prescriptions given over the past 6 months	<input type="text"/> <input type="text"/>		
Please give details of any chronic disease or illness or physical defect or infirmity from which he/she suffers	<input type="text"/> <input type="text"/>		
How long was or will the patient be prevented from travelling?	From <input type="text"/> / <input type="text"/> / <input type="text"/> to <input type="text"/> / <input type="text"/> / <input type="text"/>		
Had patient planned to travel against your prior advice?	<input type="text"/> <input type="text"/>		
Did the patient travel overseas for the purpose of obtaining medical treatment or advice for medical treatment?			Yes <input type="checkbox"/> No <input type="checkbox"/>
Name of Doctor	<input type="text"/>	Signature	<input type="text"/>
Address	<input type="text"/>		
Date	<input type="text"/> / <input type="text"/> / <input type="text"/>		

CLAIMANTS DECLARATION

Declaration

I do solemnly and sincerely declare that the particulars contained in this form are true and correct in every detail and I agree that if I have made, or in any further declaration in respect of the above said claim shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the policy shall be void and all rights to recover thereunder in respect of past or future claims shall be forfeited.

Furthermore

In consideration of QBE Insurance (International) Limited agreeing to meet payment of this claim I/we hereby agree to discharge QBE Insurance (International) Limited from any further liability, claims or demands in respect of this claim. Any property which is the subject of this claim will be owned by the Insurer by virtue of the claim having been settled in respect of such property.

Privacy Act

I acknowledge that QBE Insurance (International) Limited require this personal information from me before it will decide whether to accept this claim. This information will be retained and held by QBE Insurance (International) Limited. I understand that the Privacy Act entitles me to have access to and require correction of this information. I authorise QBE Insurance (International) Limited to disclose this information to its advisers, other insurers, to reinsurers and other parties. I further authorise QBE Insurance (International) Limited to obtain information about me held by any other party that is in its view relevant to this claim.

Medical authority

I hereby authorise any hospital, physician or other person who has attended me to furnish to QBE Insurance (International) Limited or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and all copies of hospital or medical records. I agree that a photostat copy of this authorisation shall be considered as effective as the original.

Signature	<input type="text"/>	Date	<input type="text"/> / <input type="text"/> / <input type="text"/>
-----------	----------------------	------	--