CLAIM FORM ➲

Medical Travel Shield

EXTF170

Call ATC for assistance on 1800 994 694

1. This claim form must be completed by a **covered person** under the policy.

2. Check all relevant questions have been answered (including by selecting either Yes or No wherever this option is given) and the declaration has been signed and dated.

3. It will also assist the claim decision making process if **you or your companion** attach a complete copy of the signed contract relevant to this claim when submitting your claim form.

4. Please keep a copy of the completed claim form and attachments for your records.

5. Send or scan and email, or deliver your completed form in person to:

   Post: ATC Insurance Solutions Pty Ltd
   Level 4, 451 Little Bourke Street,
   Melbourne Vic 3000
   Email: info@atcis.com.au

ATC Insurance Solutions Pty Ltd Telephone (03) 9258 1770 Email info@atcis.com.au Web www.atcis.com.au

Covered Person

The provision of this form by ATC is not an admission of liability or acceptance by ATC of your claim. All questions in this section must be answered.

Title_____ First name_____ Last name_____

Occupation_____ Home telephone_____

Work telephone _____ Mobile_____ Date of birth _____/_____/_____

Email_____

Home address_____

Suburb_____ State_____ Postcode_____

Postal address (if different from above)_____

Suburb_____ State_____ Postcode_____

Purpose of journey: ◯ Fertility ◯ Cosmetic ◯ Dental ◯ Elective Procedure_____

Electronic Funds Transfer

If your claim is approved and you wish to have the payment transferred directly to your bank account, please provide your account details

Bank name_____ Bank branch_____

Account name_____

BSB ____ /____ /____ – ____ /____ /____ Account no._____

SECTION 1 ➲ Medical and Additional Expenses

1. Type of injury or sickness_____ Date of accident or commencement of sickness_____/_____/_____
2. Injury – Give full details of accident _____

_____

_____

3. Date of first medical consultation _____/_____/_____ Name of doctor or hospital _____
4. Details of other treatment by doctors/hospital_____

_____

_____

5. Dates in hospital Admitted_____/_____/_____ am ◯ pm ◯ Discharged_____/_____/_____ am ◯ pm ◯
6. Have you ever suffered from the same or a similar complaint in the past? Yes ◯ No ◯ If yes, please provide details, dates, etc.

_____

_____

7. Is the sickness/injury a result of, or a complication from the treatment or procedure for which your trip was intended?

   Yes ◯ No ◯

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Original doctor's/hospital accounts and receipts.
- Original doctor's certificate.

Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason:

_____

_____

SECTION 2 ➲ Cancellation and Curtailment

1. What was the reason for the cancellation or curtailment of your trip?

_____

_____

_____

2. If cancellation/curtailment is the result of a sickness or injury:

   a. Date of first medical treatment _____/_____/_____

   b. Has the injured/sick person had a similar condition in the past? Yes ◯ No ◯

   c. Name of patient's normal doctor _____

   d. Address of patient's normal doctor _____

   _____

3. Date you advised travel agent or provider(s) to cancel bookings _____/_____/_____

   Amount of deposit paid and date paid $_____ Date_____/_____/_____

   Balance of full fare and date paid $_____ Date_____/_____/_____

   Total paid $_____

   Refund received on cancellation $_____

   Full amount being claimed $_____ (excluding Insurance premium)

4. Were any alternative arrangements offered or made (Please provide details)

_____

_____

_____

5. Were any additional fares incurred as a result of cancellation (Please provide details)

_____

_____

_____

(Complete this section for additional expenses)

6. Reason for incurring additional expenses or forfeiting travel or accommodation expenses

_____

_____

_____

7.

DETAILS OF EXPENSES INCURRED	AMOUNT (AUS $)
_____	$_____
_____	$_____
_____	$_____
_____	$_____
	Total $_____

SECTION 2 ➲ Cancellation and Curtailment continued

8. Were these expenses incurred as a result of injury or sickness as claimed on previous page? Yes ◯ No ◯

9. If these expenses were incurred as a result of injury or sickness to any other person, please give details of cause, name, address and age of person.

   a. Cause _____

   b. Name & details _____

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Original receipts and/or tickets relating to additional expenses incurred.
- Proof of cause i.e. original doctor's/hospital's certificate relating to injured or sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport.

Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason:

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_____

SECTION 3 ➲ Property & Money

This form must be fully completed in the sections applicable to your claim and signed.

1. Give full details of how loss damage or theft occurred: (Detail each event)

_____

_____

_____

2. Date of occurrence ____/____/_____ Time of occurrence_____ am ◯ pm ◯

3. Date of reported ____/____/_____ Time of reported_____ am ◯ pm ◯

4. Loss reported to

   Title_____ First name_____ Last name_____

   Suburb_____ State_____ Postcode_____

5. Were articles lost by carrier (e.g. airline)? Yes ◯ No ◯ Name of carrier_____

6. Have you yet lodged a claim or complaint against any carrier/airline or other authority or against any individual responsible for the loss or damage to your property? If so, please provide details and attach copies of correspondence

   NOTE: The Warsaw convention imposes a liability upon the carrier and you must submit a claim to them before claiming against this insurance.

AIRLINE	CLAIM NUMBER

SECTION 3 ➲ Property & Money continued

7. Are any of the items covered by other Insurance? Yes ◯ No ◯ If Yes, which company?_____

8. Were all the missing articles your property? Yes ◯ No ◯ If not, who is owner?_____

9. Description and size of suitcase in which missing goods carried

_____

_____

_____

10.

Full details of articles claimed (include value of cases)	Name and address from whom goods were purchased	Date of purchase	Purchase price	Deduction for deprec.	Amount claimed	Remarks
			$	$	$	
			$	$	$	
			$	$	$	
			$	$	$	

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Report or letter from authority (e.g. police, airline) regarding the loss, where available.
- Proof of purchase of lost goods (e.g. receipts, guarantee or valuation certificates, card vouchers, etc.)

Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason:

_____

_____

_____

SECTION 4 ➲ Additional Return Trip

1. Describe in detail the medical complication resulting in your need to return overseas

_____

_____

_____

_____

2. Name and address of accommodation

_____

_____

_____

_____

3. Airline_____ Ticket value $_____

SECTION 5 ➲ Personal Liability

1. Bodily injury – Please provide relevant details – Name and address of injured party and details of injury

   a. Title_____ First name_____ Last name _____

   Address _____

   Suburb _____ State_____ Postcode_____

   b. Details of injury

   _____

   _____

   _____

   _____

2. Damage to property – Please list all property damage together with name and address of party claiming damage against you

   a. Title_____ First name_____ Last name _____

   Address _____

   Suburb _____ State_____ Postcode_____

   b. Details of property damage

   _____

   _____

   _____

   _____

3. Is the bodily injury or property damage related to a travelling companion? Yes ◯ No ◯

4. Do you consider you were at fault? Yes ◯ No ◯ (If Yes, why)

_____

_____

_____

_____

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

- Letters or demands of a claim made against you

Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason:

_____

_____

_____

_____

PLEASE KEEP A PHOTOCOPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORD

SECTION 6 ➲ Declaration

Privacy Act

In this statement "we", "us" and "our" means Lloyd's and ATC Insurance Solutions (ATC) as its agent.

We are bound by the requirements of the *Privacy Act 1988* (Cth), the Privacy Amendment *(Private Sector) Act 2000* (Cth) and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. This sets out standards on the collection, use, disclosure and handling of personal information.

Our Privacy Policy is available at www.atcis.com.au or by calling us on the number below.

We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties (and/or collect additional personal information about you from them) who assist us in providing the above services and some of these are likely to be overseas recipients in the United Kingdom. These parties which include our related entities, distributors, agents, insurers, claims investigators, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Medicare Australia and Centrelink will only use the personal information for the purposes we provided it to them for (unless otherwise required by law).

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made 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 and request correction if required. You may also opt out of receiving materials sent by us by contacting ATC on (03) 9258 1700 or write to us at the address given on page one.

Authority & Declaration

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to ATC or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Workers' Compensation claims, claims with any other insurer or any leave benefits and payments, to be released to ATC. I agree that a photocopy or fax copy of this authorisation shall be considered as effective and valid as the original.

I declare that:

my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.

Signature _____

Name (print) _____ Date _____/_____/_____

Important notice: If you have declared this claim is not work-related and a claim is made under this policy that is rightfully a workers' compensation claim, it is possible a fraudulent act has been committed that may result in prosecution. You must tell us if you return to work or become medically fit to do so. If you fail to tell us and continue to receive benefits under the policy you could be prosecuted for fraud. You might also lose all of your rights under the policy for this claim and any future claims.