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Claim Form
Travel Insurance

Important: Please read before you complete this form

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. Please note that Sections 1, 2, 3, 4, 5 & 12 are compulsory.
3. Note: This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by AHI.

01. Your Details

All Questions Require Completion

Policy Number: 23171

Expiry Date: 30/11/2023

Name of Insured Company: The South Australian Government

Your Position

☐ CEO/COO ☐ Director ☐ Employee ☐ Spouse ☐ Dependent Child ☐ Other

Title | Given Name(s) | Gender ☐ M ☐ F ☐ Other

Family Name | Date of Birth

Residential Address (cannot be a PO Box) | Suburb | State | Postcode

Email Address | Daytime Contact Number | Alternative Number

Are you able to claim through any other source? ☐ Yes ☐ No

If Yes, please provide details

Have you made previous travel insurance claims? ☐ Yes ☐ No

If Yes, please provide details

02. Payment Details

Compulsory

Please provide bank and account details for payment

Account Holder's Name

BSB Number (6-Digits) | Account Number | Bank

(Alternatively supply a deposit slip noting the following information)

03. GST Declaration

Must be completed only in respect of:

- Each company owned item
- Any other expenses where Australian GST is incurred by the company.

Are you registered for GST Purposes? ☐ Yes ☐ No

If Yes, What is your ABN?

Have you ever claimed, or are you entitled to claim an Input Tax Credit (ITC) in respect to GST paid on the insurance policy under which this claim is being made? ☐ Yes ☐ No

If Yes, what percentage of ITC did you claim or are you entitled to claim?

04. Travel Information

Compulsory

Departure Date

Return Date

Departure City

Destination City

Departure Country

Destination Country

Reason for Travel

☐ Business / Work ☐ Holiday ☐ Combination ☐ Other

05. Details of Incident

Compulsory

Date of Incident | Time | AM / PM | Incident City | Incident Country

Please describe how the accident / damage / theft / loss / illness occurred and complete relevant sections

06. Medical Expenses

If Applicable

- This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.
- Medical Receipts will be required to accompany this section.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the curtailment of the journey.
- All medical and hospital accounts Incurred within Australia must first be submitted to Medicare for refund, also to your private health fund if applicable.

Was the Emergency Assistance Company contacted? ☐ Yes ☐ No

If an illness, has the claimant suffered this complaint before? ☐ Yes ☐ No

If Yes, please provide details

Date of Expense	Medical and/or Hospital Expenses (use separate sheet if insufficient space)	Amount Claimed (Please state currency)

07. Lost, Stolen or Damaged Luggage & Personal Effects

If applicable

- In the event of loss or damage occurring whilst in the care of carriers (airlines, bus companies, etc) the carrier should have been notified and a Property Irregularity Report obtained and forwarded with this form.
- Full description of articles lost or damaged with details of the nature of damage, full particulars of purchase price and date and place of purchase are to be entered on the statement of claim below, together with proof of lost or damaged goods (e.g. Receipts, Valuation, Certificates, Credit Card Statements).
- You should obtain an estimate for repairs where feasible or written confirmation from a competent repairer or dealer that the articles are damaged beyond economic repair.
- All optical expenses must first be submitted to your health fund, if applicable.
- Lost/Stolen goods should be reported to the Police.

Was the incident reported to Police or any other authority? Yes No

If Yes, please provide report / Incident No.

If No, please provide explanation:

Were articles lost by a carrier? Yes No

Note: The Warsaw Convention & The Montreal Conventions imposes a liability upon the carrier and you should claim against them first.

Were all the missing articles your property? Yes No If No, Who is the owner?

Have you 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? Yes No

If Yes, please provide details and attach correspondence:

If No, please provide explanation:

If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? Yes No

Name of Fund

Membership Number

Amount Paid by Health Insurer

Currency

08. Delayed Baggage

If applicable

Date of Your Arrival

Time

AM/PM

Compensation Paid by Carrier

Currency

Date of Luggage Arrival

Time

AM/PM

Statement of Claim

Attach separate sheet if insufficient room
Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the damage where applicable.
Please attach relevant documentation to support your claim, e.g. receipts, photographs, manuals.

Full description of article/s & details of damage where applicable (provide evidence)	Original Cost Price	Date and Place of Purchase	Has item been replaced	ITC%	Amount Claimed	CUR
e.g Dell Latitude x150 - Cracked Monitor – photo #1	*$2,600 AUD*	*26/06/2018 - Dell website*	*No*	*65%*	*$2,600*	*US*

09. Additional And/Or Expenses

If applicable

- This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.
- Only original accounts or receipts for accommodation and transport costs will be accepted.
- For additional expenses, a MEDICAL CERTIFICATE, or the Medical Certificate on Page 6 of this form, from the doctor who treated you must be provided to support change of plans due to accident, illness or death.

If you are claiming for additional expenses, what were your original plans for accommodation / transport and how were they changed?
Please ensure copies of original and amended itineraries are provided.

Date of Expense	Additional Transport / Accommodation Expenses (Please supply Full Details)	Amount Claimed (Please state currency)

Date of Expense	Forfeited Expenses (Please supply Full Details)	Amount Claimed (Please state currency)

10. Hire Car Expenses

If applicable

Please ensure a copy of your Hire Vehicle Agreement, Damage Report and repair invoice(s) are attached.

Name of Vehicle Hire Company

Car Other

Title

Driver's Full Details

Rental Vehicle Excess $ Currency

Actual Repair Costs $ Currency

Amount you are claiming $ Currency

11. Cancellation / Loss of Deposits

If applicable

- If you are claiming because you cancelled your trip PRIOR to departure, as a result of injury, illness or death, you MUST have the Medical Certificate on Page 6 completed by the regular doctor of the person whose state of health has resulted in the claim.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the cancellation of the journey.
- A supporting document from the travel provider showing cancellation charges must be submitted with this form.

Date travel arrangements booked:

Date of Cancellation:

Reason for Cancellation:

If cancellation is due to accident, illness or death state the name of the person whose accident, illness or death necessitates the cancellation of the travel. IN THE EVENT OF DEATH, PLEASE ATTACH DEATH CERTIFICATE

Title

Given Name(s)

Family Name

Relationship of person to claimant

Amount Paid

Currency

$

Amount Refunded

Currency

$

Amount Claiming

Currency

$

If no refund amount is noted please state why (you must obtain all refund possible)

12. Declaration

Compulsory

General Insurance Code of Practice
AHI proudly support the General Insurance Code of Practice (the 'Code'). The purpose of the Code is to raise the standards of practice and service in the general insurance industry. For further information on the Code, please visit www.codeofpractice.com.au.

Complaints and Disputes Resolution
If you have a dispute and after talking to AHI, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within 15 business days in accordance with the General Insurance Code of Practice. If you still remain dissatisfied after proceeding with the above, our process includes advising you on how to contact the insurance industry's external independent complaints scheme, the Australian Financial Complaints Authority (AFCA). Access to this scheme is free of charge to you.

Privacy Declaration
I/We agree that, by submitting this form, the personal information I/we provide to AHI in this form or otherwise may be collected, held, used and disclosed in the manner set out in the AHI Privacy Policy found at www.ahiinsurance.com.au, including for the processing of this claim.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:
I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

Authority
I authorise any hospital and/or physician who has treated me to provide AHI with copies of medical records or of my past medical history, as requested.

Signature of Claimant

Date

Signature of the Insured (if other than claimant)

Date

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Medical Certificate

The claimant must obtain at own expense from the patient's usual doctor in all cases
Important: the medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries

13. Patient Details

Compulsory

Title | Given Name(s) | Date of Birth

Family Name

1. Are you his/her usual medical attendant? ☐ Yes ☐ No

2. If Yes, for how long? ☐☐ Days ☐☐ Months ☐☐ Years

3. Please give precise details of the nature of the illness or injury.

4. Start date of onset of illness, or date

5. State date on which you were first consulted in relation to the condition described above and, in your opinion, how long the condition has been present prior to consultation.

First Consultation Date | Condition has been present prior to consultation for:

6. Are you prepared to certify that solely due to the condition described in question 3, the claimants was/were compelled to cancel the travel arrangements? ☐ Yes ☐ No

7. What treatment, if any, has your patient previously received for this or any other related condition, and when was treatment received?

8. Is he/she suffering from any chronic disease or illness or from any physical defect or infirmity?

9. If the claim is as a result of a death, in your opinion, was it sudden and unexpected? Please give reasons for your answer.

Print Name | Qualification | Signature

Address | Phone | Fax | Date