Corporate Travel Insurance

CLAIM FORM

AFA INSURANCE

1. There are two sections to this claim form:
   Part A: Compulsory: please complete all sections of Part A.
   Part B: Claim Information: this part is broken down into sections. Please complete the relevant section/s that are applicable to your claim.
2. To avoid any unnecessary delays in the processing of this claim, please ensure that all applicable questions are answered fully and all the supporting documentation specified in the section/s relevant to your claim are provided with this form.
3. Please send claim form to and all supporting documentation to:
   Claims Manager, Fullerton Health Corporate Services
   mail: Level 10, 33 York St, Sydney, NSW, 2000
   email: claims@fullertonhealthcs.com.au
   fax: +61 2 8256 1775

This is the form to use when making a Corporate Travel claim with AFA Pty Ltd. Correct completion of this form will assist us to make accurate and faster decisions regarding our customers' claim for benefits and ensure that where benefits are payable that they reach our customers in a timely manner. Incomplete claim forms will be returned for completion and will lead to assessment delays.

PART A – COMPULSORY

Please complete all sections of Part A. Any incomplete sections will lead to delays in assessment.

INSURED PERSON'S DETAILS

Policy number

Employer/company

Your name

Sex Female ☐ Male ☐

Nationality

Your position
Employee ☐ CEO ☐ CFO ☐ COO ☐
Director ☐ Company Secretary ☐ Contractor ☐ Spouse/Partner ☐
Dependent child ☐ Other

Date of birth / /

Home phone no. ( )

Work phone no. ( )

Mobile phone no.

Email Do you consent to communication via email? No ☐ Yes ☐

Address

Postcode State

PAYMENT DETAILS

Should your claim be accepted and benefits are payable, the payment will be credited direct to your bank account. Please provide your bank details below.

Bank name

Account name

BSB number

Account number

IBAN number

Swift Code (for non Australian bank)

GST INFORMATION (FOR AUSTRALIAN CLAIMS ONLY)

Please complete for:

- each company owned item
- any other expenses where Australian GST is incurred by the Insured.

Are you registered for GST purposes? No Yes

What is your Australian Business Number (ABN)?

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

If yes, please provide the percentage you claimed or are entitled to claim.
(Note: if the GST is paid and your ITC entitlement are the same amounts, the answer to the question is 100%)

%

OTHER INSURANCE

Are you a member of a private health insurance fund? No Yes please provide name of the fund

Note: If applicable all medical accounts must first be lodged with your private health fund before submitting this claim.

Did you pay for your trip on a credit card? No Yes please provide details

Bank name

Card type (eg Visa Gold, Platinum)

Do you have Home and Contents Insurance? No Yes please provide details

Insurer name

Policy number

TRAVEL INFORMATION

Date of departure / /

Date of return/expected return / /

Was this authorised business travel? No Yes

Reason for travel

- Business related
- Holiday or leisure trip only
- Combination of business and leisure
- Other

Departure city, country

Destination city, country

Type of travel Air Sea Rail Bus Hire car Other (please specify)

TRAVEL AUTHORISATION

This section must be completed by the AUTHORISED COMPANY REPRESENTATIVE who approved the above listed travel

Name

Position

Company

I hereby confirm that (claimant name) is an insured person and was on authorised business travel for my company on the date of loss.

Signature

Date / /

INCIDENT DETAILS

Type of incident (eg accident, theft, damage, loss, Injury, illness, death, other)

Date of incident / /

City and country of incident

Describe how the accident, theft, damage, loss, Injury, illness occurred

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

Police/Authority number

PART B – CLAIM INFORMATION

Please complete the relevant section/s applicable to your claim. If insufficient space, please attach separate sheet(s).

PERSONAL ACCIDENT AND SICKNESS CLAIM

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Completed medical certificate (obtained for your Doctor)
- Medical/hospital reports detailing the claimants treatment, diagnoses and outcome;
- Completed Medical Certificate (see last page of claim form)

Failure to provide these items may result in delays in processing your claim.

Does your claim arise from an Injury or Sickness? No Yes please provide full details of the Injury or Sickness

Date of first medical consultation / /

Name of doctor and/or hospital

Name and address of usual treating doctor

City and country where you were treated

Details of any other treatment by doctor and/or hospital

Final diagnosis and outcome

Dates in hospital Admitted / / Discharged / /

Did you cease all work duties as a result of this Injury or Sickness? No Yes

Are you entitled to, and/or have you made or intend to make a claim for benefits of any type in regard to this Injury or Sickness? (e.g workers' compensation, travel insurance)

No Yes please provide full details

Are you in receipt of wages, salary, paid sick leave or income from any other source? No Yes please provide full details

Have you returned to work in a full time or part time capacity? No Yes please provide full details

Include capacity and state the date on which you first returned to work

If you have not returned to work, when do YOU expect that you will be able to do so?

If you have not yet returned to work, how is the Injury or Sickness preventing you from working?

DEATH CLAIM

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Medical/hospital report/s detailing the claimants injury or sickness
- A copy of the deceased's Death Certificate
- A copy of Coronor's Depositions and Findings.

Failure to provide these items may result in delays in processing your claim.

Name of deceased person

Details of the person completing this claim form:

Name

Date of birth / /

Address

State

Home phone no. ( )

Work phone no. ( )

Mobile phone no.

Email address

Relationship to the deceased

Date and time of death / / at am / pm

Cause of death

Date of accident or Sickness from which the death occurred / /

Address where the death occurred

State

Were there witnesses to the death? No Yes please provide full details including full name of witness and contact number etc

Did Police attend the scene of the death? No Yes please provide full details including the police station, police officer's name, event number etc.

Has there been a coronial inquest or is one to be held? No Yes please provide details

Are you aware of the deceased suffering from a Sickness or disease which may have contributed to the death?

No Yes please provide details

Name of deceased's estate or legal representative

MEDICAL EXPENSES AND EMERGENCY EVACUATION

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Medical/hospital/dental report detailing treatment and diagnosis
- Change to completed medical certificate (obtained for your Doctor)
- Itemised accounts giving breakdown and description of costs claimed, together with receipts of any accounts have been paid.

Failure to provide these items may result in delays in processing your claim.

Please note: all medical accounts must first be lodged with your Private Health Fund if applicable. The policy is only able to consider non-medicare related expenses.

Type of Injury or Sickness

Date of accident or commencement of Sickness / /

Full details of Injury or Sickness

City or country of incident

Date of first medical/dental consultation / /

Name of doctor/hospital

Details of any other treatment by doctor and/or hospital

Dates in hospital Admitted / / Discharged / /

Have you ever suffered from the same or similar Injury or Sickness No Yes please provide full details

Date / /

Name(s) of treating physicians

Address(es) of treating physicians

Name and address of usual treating doctor

Was travel undertaken for the purpose of seeking medical treatment overseas? No Yes please provide full details

Was the Emergency Assistance Service contacted? No Yes

Please provide details of Medical Expenses and Emergency Evacuation below. If insufficient space, please attach separate sheet

Name of doctor, dentist, pharmacy, hospital or provider	Treatment provided	Date of treatment	Amount charged	Paid Yes/No	Refund from health funds

LUGGAGE AND PERSONAL EFFECTS CLAIM

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Itemised receipts for the purchase of all claimed items
- Withdrawal confirmation of any money lost of stolen
- Police or airline report (where applicable)
- Response from transport provider after claim (where applicable).

Failure to provide these items may result in delays in processing your claim.

Type of claim(s) Loss Damage Theft

Time and date of the event / / at am / pm

Full details of how loss, damage, theft occurred (if insufficient space, attach separate sheet).

Was the event reported to police? No Yes please provide details of the report

Reported to

Time and date of the report / / at am / pm

Report/event number (if applicable)

Were articles lost or damaged by the carrier? No Yes please provide name of carrier

Is this a misplaced luggage or personal effects claim? No Yes please provide details

City and country where items were lost

Date and time when items were returned to you / / at am / pm

City and country where items were returned

Have you made a claim or complaint against any carrier, airline, hotel, other authority or against any individual responsible for the loss or damage to your property? Note: the Warsaw/Montreal Convention imposes a liability upon the carrier and you must claim with them first. No Yes please attach details and copies of correspondence.

Are any of the items covered by any other insurance? No Yes please provide details

The name of the insurer

The policy number

List of items being claimed (if insufficient space, please attach separate sheet)

Item description	Name and address where items were purchased	Date of purchase	Original purchase price (specify currency)	Amount claimed (specify currency)

LOSS OF DEPOSITS, CANCELLATION AND CURTAILMENT CLAIM

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Completed medical certificate (obtained for your Doctor) if applicable
- Copy of original itinerary
- Receipts and/or tickets and credit card/bank statements showing amounts paid for in the original itinery
- If travel was cancelled due to medical reasons or death, please include completed medical certificate and copy of Death Certificate
- Letter from travel agent confirming total cost of journey, value of unused portion of journey, cancellation charges and total amount of refund received
- Doctor/Hospital certificate specifying exact nature of condition suffered by the Injured/Sick Person
- Any other documentation relating to loss of deposits, cancellation and curtailment.

Failure to provide these items may result in delays in processing your claim.

Was the cancellation as a result of an Injury or Sickness to yourself? No Yes

Was the cancellation as a result of an Injury, Sickness or Death to some other relative or person defined in the Policy? No Yes please provide details

Please provide the reason why the proposed journey could not commence or be completed?

If the journey was cancelled as a result of an Injury, Sickness or death please provide the name of the person whose Injury, Sickness or death resulted in the cancellation of the journey:

Name

Date of birth / /

Address (if not claimant)

State

Relationship

Nature of Injury or Sickness

Date of first medical treatment / /

Has the Injured/Sick person had a similar condition in the past? No Yes please provide full details

Name and address of their usual treating doctor

Please provide details of loss of deposits, cancellation and curtailment expenses. If insufficient space, please attach separate sheet:

Date of booking	Date of cancellation	Description of booking	Supplier	Amount paid	Refund received	Amount claimed (specify currency)	Alternative arrangements offered? yes/no

HIRE CAR EXCESS CLAIM

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Proof of payment of expense
- Notice from the applicable company in respect of the excess payable
- Report made to the police or other authority (if applicable)
- If claiming for Hire Car Excess Benefit, please include a copy of the rental vehicle agreement, notice from the rental company in respect of the excess and documentation showing payment of excess
- If claiming for Personal Motor Vehicle Excess Benefit, please include a copy of the Insured Person's comprehensive motor vehicle policy document, receipts (or copies) for the amount of the claim or excess paid and the name of the firm which carried our the repairs on the Insured Person's personal Motor Vehicle, a letter from the Insured Person's motor vehicle insurer stating the amount of the excess paid and the amount of any no-claim bonus forfeited, a synopsis of the total cost of the repairs (with complete details if possible)
- If claiming for Home Insurance Excess Benefit, please include a copy of the Insured Person's home insurance policy document and police report.

Failure to provide these items may result in delays in processing your claim.

Type of claim Hire car excess Personal motor vehicle excess Home insurance excess

Date of incident / /

Location of accident/incident

Please provide full details of the incident that gave rise to the claim? If insufficient space, please attach separate sheet.

PERSONAL LIABILITY AND LEGAL CLAIM

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Correspondence received regarding the claim made against you, a written summary of the circumstances that led to this claim and any further comments you wish to provide
- Quotations or receipts in support of claim made against you.

Failure to provide these items may result in delays in processing your claim.

Type of claim: Death or bodily Injury to another person please proceed to question 2

Damage to property of another person please proceed to question 3

Death or Injury – please provide all relevant details (if insufficient space, please attach separate sheet).

Address where incident occurred

State

Details of death or injury
Damage to property – list all property damaged, with name and address of party claiming damage against you (if insufficient space, please attach separate sheet).

Name of party claiming damage

Address of the damaged property

State

Details of property damaged

Is the Injury or damage relating to a travelling companion? No Yes please provide full details

Do you consider you were at fault? No Yes please provide full details

ADDITIONAL EXPENSES CLAIM

Please attach the following documentation (photocopies can be submitted. If originals are submitted keep copies):

- Copy of original itinerary;
- Receipts, bank statements and/or credit card statements showing amounts paid for original itinerary;
- Proof of payment for additional expenses claimed (i.e tax invoices, receipts, credit card/bank statements showing payments made);
- If the additional expenses were incurred due to medical reasons or death, a completed Medical Certificate (see last page of claim form) must be completed and copy of Death Certificate (if applicable)
- Letter from travel agent or carrier verifying reason for additional expenses and or any refund applicable
- Doctors/Hospital Certificate specifying exact nature suffered by Injured/Sick Person.

Failure to provide these items may result in delays in processing your claim.

Reason for additional expenses? (If insufficient space, please attach separate sheet.)

Please state the reason/event that caused the additional expenses? (If insufficient space, please attach separate sheet.)

Please list each expense separately in the table below. (if insufficient space, please attach separate sheet)

Description of expense/s	Location	Date of expense	Amount	Currency

MEDICAL AUTHORITY/ACCESS TO INFORMATION

I understand that AFA Pty Ltd (ABN 83 067 084 33, AFS License No. 247122), Fullerton Health Corporate Services (Aust) Pty Ltd (ABN 30 074 864 609 or AWP Australia Pty Ltd (ABN 52 097 227 177, AFS License No. 245631) may need to access, collect and disclose information about me in order to be able to assess my claim for benefits.

In order to do so, I (insert your full name here)

of (your address)

hereby agree that I have read and understood and agree to the collection, use and disclose of my personal information by AFA Pty Ltd, AWP Australia Pty Ltd and Fullerton Health Corporate Services (Aust) Pty Ltd, to collect and disclose any information about me from and to any organisation or person including the following (which includes their current and former capacities and any organisation or person that may replace them); Medicare; any insurance or health insurance company, other insurance intermediaries, Centrelink, any hospital, physician, medical practice, medical services provider, medical therapy provider, employer, airlines, travel agents, hotels, police, investigators, assessors and loss adjustors, other parties we may be able to claim or recover against, insurance reference bureau, financial institutions including banks, the Australian Taxation Office and my accountant.

In providing or obtaining information about me, I understand that AFA Pty Ltd, AWP Australia Pty Ltd and Fullerton Health Corporate Services (Aust) Pty Ltd will use that information in the assessment of my claim, and that if I do not provide, or permit access to this information my claim may not be able to be assessed by AFA Pty Ltd, AWP Australia Pty Ltd and Fullerton Health Corporate Services (Aust) Pty Ltd.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd, AWP Australia Pty Ltd and Fullerton Health Corporate Services (Aust) Pty Ltd, notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I have made any misrepresentations, false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that subject to law, the policy may be cancelled and/or AFA Pty Ltd, AWP Australia Pty Ltd and Fullerton Health Corporate Services (Aust) Pty Ltd may refuse to pay a claim.

Signature

Date

/ /

To be completed if another person has signed on behalf of Insured Person:

Name of person who signed on behalf of the insured person

Relationship to the insured person

Reason why the insured person could not sign

PRIVACY NOTICE

At AFA Pty Ltd (AFA) (ABN 83 067 084 333) we are committed to protecting your privacy in accordance with the *Privacy Act 1998* (Cth) and the Australian Privacy Principles (APPs). This privacy notice details how we collect, disclose and handle your personal information as defined in the Act. Personal information is essentially information or an opinion about an identified individual or an individual who is reasonably identifiable, whether the information or opinion is true or not and whether recorded in a material form or not.

WHY WE COLLECT YOUR PERSONAL INFORMATION

We collect your personal information (including sensitive information) so we can:

- identify you and conduct necessary checks;
- Determine what service or products we can provide to you e.g offer our insurance products;
- issue, manage and administer services and products provided to you or others, including claims investigation, handling and settlement;
- improve our services and products e.g training and development of our representatives, product and service research and data analysis and business strategy development.
- improve our services and products e.g training and development of our representatives, product and service research and data analysis and business strategy development.

WHAT HAPPENS IF YOU DON'T GIVE US YOUR PERSONAL INFORMATION?

If you choose not to provide us with the information we have requested, we may not be able to provide you with our services or products or properly manage and administer services and products provided to you or others.

HOW WE COLLECT YOUR PERSONAL INFORMATION

Collection can take place through websites (from data you input directly or through cookies and other web analytic tools), email, by telephone or in writing. We collect it directly from you unless you have consented to collection from someone other than you, it is unreasonable or impracticable for us to do so or the law permits us to. If you provide us with personal information about another person you must only do so with their consent and agree to make them aware of this privacy notice.

WHO WE DISCLOSE YOUR PERSONAL INFORMATION TO

We share your personal information with third parties for the collection purposes noted above.

The third parties include: our related companies and our representatives who provide services for us, our agents or contractors, our insurers, other insurers and reinsurers, your agents, premium funders, other insurance intermediaries, underwriting agents, Lloyd's Regulatory Division, our legal, accounting and other professional advisers, data warehouses and consultants, providers of medical and non-medical assistance and services, translators, investigators, loss assessors and adjusters, credit agencies, credit card providers and other parties we may be able to claim or recover against, your employer (if a corporate policy), anyone either of us appoint to review and handle complaints or disputes, other companies in the event of a corporate sale, merger, re-organisation, dissolution or similar event and our alliance and other business partners and any other parties where permitted or required by law.

We may need to disclose information to persons located overseas. Who they are may change from time to time. You can contact us for details or refer to our Privacy Policy available at our website afainsurance.com.In some cases we may not be able to take reasonable steps to ensure they do not breach the Privacy Act and they may not be subject to the same level of protection or obligations that are offered by the Act. By proceeding to acquire our services and products you agree that you cannot seek redress under the Act or against us (to the extent permitted by law) and may not be able to seek redress overseas.

MORE INFORMATION, ACCESS, CORRECTION OR COMPLAINTS

For more information about our Privacy practices including how we collect, use or disclose information, how to access or seek correction to your information or how to complain in relation to a breach of the Australian Privacy Principles and how such a complaint will be handled, please refer to our Privacy Policy. It is available at our website afainsurance.com or by contacting us or our Privacy Officer at AFA, PO Box R1852 Royal Exchange NSW 1225 or by email to privacy@afainsurance.com, or by telephone on 1300 728 997.

YOUR CHOICES

You consent to this use and these disclosures unless you tell us otherwise. If you wish to withdraw your consent, including for things such as receiving information on products and offers by us or persons we have an association with, please contact us.

CONTACT US

By phone: 1300 728 997. By email: privacy@afainsurance.com. In writing: PO Box R1852, Royal Exchange NSW 1225