HOUSE OF TRAVEL

Global Assistance

Allianz

TRAVEL INSURANCE CLAIM FORM

Effective 28 July 2011

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Phone: 0800 574 904
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Postal Address:
PO Box 112316
Penrose
Auckland 1642
New Zealand

This travel insurance is arranged and managed by AGA Assistance Australia Pty Ltd. trading as Allianz Global Assistance (Allianz Global Assistance) Company No. 2341888 and is underwritten by Allianz New Zealand Limited (Allianz) Company No. 445514. Allianz Global Assistance is authorised by Allianz to enter into and arrange the policy and deal with and settle any claims under it, as an agent of Allianz, not as your agent.

Claim No:

PRIVACY The Privacy Act 1988 requires us to tell you that Allianz Global Assistance as agent for Allianz collect your personal information in order to handle your claim. We may have to disclose your personal information to third parties such as other insurers, travel agents, medical practitioners, intermediaries, loss adjusters, external claims data collectors, investigators and the Insurance Reference Services (IRS), or as required by law. You have the right to seek access to your personal information at any time. Please contact Allianz Global Assistance on 0800 574 904 for access.

INTERNAL DISPUTE RESOLUTION Disputes are not an everyday occurrence, however, Allianz Global Assistance provides an internal dispute resolution process should any dispute arise. Please feel free to ask for details. If you are not satisfied with the outcome of this process, we will advise you how to contact the insurance industry's external independent complaints scheme.

FRAUD Insurance fraud places additional costs on honest policyholders. Fraudulent claims force insurance premiums to rise. We encourage the community to assist in the prevention of insurance fraud. You can help by reporting insurance fraud. All information will be treated as confidential and protected to the full extent under law. Report insurance fraud by calling +61 7 3305 8871.

STEP 1 – CLAIM FORM COMPLETION REQUIREMENTS

- Please read this claim form carefully and complete ALL steps outlined on this form, including the Declaration on page 7.
- Please use block letters.
- Please retain a copy of ALL documents for your records.
- Documents in a foreign language are required to be translated into English at your own expense.
- The claim form and ALL supporting documentation may be mailed, emailed or faxed to us. **Please note: We reserve the right to request the original receipts, reports or any other documentation be submitted in order to substantiate the claim.**
- Please refer to the specified documentation requirements that you will need to provide when lodging your claim. As each claim is unique, further information may be requested by us.
- **A copy of your Certificate of Insurance must be supplied with your claim.**
- **If any part of your claim is of a dishonest or fraudulent nature, then your claim will be denied and will be referred to the appropriate authorities.**

STEP 2 – CLAIMANT DETAILS

Policy and Claimant Details

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Name of Policyholder(s)

Name of Claimant (Mr/Mrs/Miss/Ms)

Certificate of Insurance/Policy Number

Address Postcode

Telephone Home Business Mobile

Email Address

Date of Birth / / Occupation

Travel Agent Date of Booking Travel Arrangements / /

Date of Departure / / Date of Return / /

If you wish to give authority for another person, agency or organisation to act on your behalf in respect to this claim you must complete the following details (otherwise we will not be able to give any information about your claim to any other person).

I/We, authorise (Name of person/agency/organisation)

of (Address) Postcode

Phone Mobile

to act on our behalf in respect to this claim and to be provided with information relating to the claim.

A. Previous Travel Claims History

Have you made previous travel insurance claims? Yes ☐ No ☐ If ***Yes***, please complete table below. If ***No***, please go to next step.

Date of Claim	Name of Insurer	Claim Number	Details of Claim	Amount Claimed	Amount Paid

B. Travel Arrangements

1. Did you use a credit card to purchase your travel (eg. flights, accomodation, tours)? Yes ☐ No ☐

2. If ***Yes***, please complete the following: Name on Credit Card _____ Name of Financial Institution _____

Card Type: Visa ☐ Mastercard ☐ Diners ☐ Amex ☐ **Card Level:** Gold ☐ Platinum ☐ Other _____

STEP 3 – CLAIM INFORMATION

In this Section we will ask you the circumstances of your claim and the amount that you are claiming. Please tick the applicable box(s) relating to your claim and answer the corresponding Section.

☐ **A.** Overseas Medical, Dental and/or Hospitalisation Expenses Claim – *please see below*
☐ **B.** Cancellation Charges/Loss of Deposit Claim (Cancellation of Pre-paid Arrangements) – *please go to page 3*
☐ **C.** Additional Expenses Claim (Additional Travel or Accommodation Expenses) – *please go to page 3*
☐ **D.** Luggage and Personal Effects Claim – *please go to page 4*
☐ **E.** Rental Vehicle Excess Claim – *please go to page 5*
☐ **F.** Delayed Luggage Expenses Claim – *please go to page 5*
☐ **G.** Other – *please go to page 6*

Please answer all questions relating to what is being claimed, otherwise we will be unable to process your claim.

A. Overseas Medical, Dental and/or Hospitalisation Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Copy of your Certificate of Insurance.
2. Medical/Hospital/Dental Report detailing Treatment and Diagnosis.
3. Itemised accounts giving a breakdown and description of costs claimed, together with receipts if any accounts have been paid by you.
4. Completed Medical Certificate (see last page of claim form).

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

Type of Injury or Sickness _____ Date of Accident or Commencement of Sickness / /

If injury - Give full details of Accident

Date of First Medical/Dental Consultation / / Name of Doctor, Dentist and/or Hospital _____

Details of other treatment by Doctor, Dentist and/or Hospital _____

Dates in Hospital - Admitted / / am/pm Discharged / / am/pm

Did you contact our Emergency Assistance department? Yes ☐ No ☐

Have you ever suffered from the same or similar injury or sickness in the past? Yes ☐ No ☐

If Yes, give details including dates, names and addresses of treating physicians

Name and Address of usual family doctor

Please list each receipt/bill separately in the table below. Claims will be converted to New Zealand dollars using the currency rate applicable at the date and time the expenses were incurred.

Name of Doctor/Dentist/Pharmacy/ Hospital or Provider	Treatment Performed	Date of Treatment	Amount Charged (State Currency)	Paid Yes/No	Refund from Health Funds
e.g. Doctor R Smith	e.g. Consultation	e.g. 10/02/07	e.g. EUR 100	e.g. Yes	e.g. EUR 75

B. Cancellation Charges / Loss of Deposit Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Copy of your Certificate of Insurance.
2. Copy of original Itinerary.
3. Terms and Conditions issued by Travel Agent and/or Transport, Tour or Accommodation Provider.
4. Letter from Travel Agent or, where travel was not arranged through a Travel Agent, a letter from the relevant organisation through whom travel was booked, confirming payments made, refunds given and any amounts you are out of pocket.
5. Proof of payment for trip (ie. receipts, credit card/bank statements showing payments made).
6. If travel was cancelled due to Medical Reasons/Death - completed Medical Certificate (see last page of claim form) and copy of Death Certificate (if applicable).
7. If travel was cancelled by a Transport Provider - letter from them explaining the circumstances of the cancellation and any refund/compensation paid or payable to you.

*** Failure to provide this documentation may result in delays in processing your claim.**

What was the reason why you could not commence or complete your proposed Journey?

Was your Journey cancelled as a result of Injury/Sickness to yourself? Yes ☐ No ☐

Was your Journey cancelled as a result of Injury/Sickness to any other person? Yes ☐ No ☐

If Yes, please provide

Full Name _____ Date of Birth / /

Address _____ Relationship _____

Nature of Injury/Sickness _____

Date your Journey was booked: / / Date your Journey was cancelled / /

Details of Journey

Date	Description of Booking	Supplier	Amount Paid	Refund Received	Amount Claimed

C. Additional Expenses Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Copy of your Certificate of Insurance.
2. Copy of orginal Itinerary.
3. Receipts, bank/credit card statements showing amounts paid by you for original Itinerary.
4. Proof of payment for additional expenses claimed (ie. tax invoices, receipts, credit card/bank statements showing payments made).
5. If the additional expenses were incurred due to the unfortunate event of a death - a copy of the Death Certificate.
6. If the additional expenses were incurred due to a Transport Provider - letter from them explaining circumstances and any compensation paid to you.

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

Please state the reason/event that caused the additional expenses being incurred

What was the unexpected expense incurred? _____

Please list each receipt/bill separately in the table below. Claims will be converted to New Zealand dollars using the currency rate applicable at the date and time the expenses were incurred.

Date of Expense	Description of Expense	Amount	Date of Original Plan	Description of Original Cost	Amount
e.g. 24/07/07	e.g. Hotel in Paris	e.g. EUR 100	e.g. 24/07/07	Flight to Munich	e.g. EUR 75

D. Luggage and Personal Effects Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Copy of your Certificate of Insurance.
2. Proof of ownership of the items claimed (ie. tax invoices, receipts, or credit card/bank statements proving purchase of the item/s).
3. Report made to the Transport Provider/ Police/Hotel or other appropriate Authority.

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

Give full details of how losses, damage or thefts occurred: (Detail each event)

Date loss/damage occurred / / Time am/pm Location/Country

Date loss/damage reported / / Time am/pm Location/Country

Loss/damage reported to - (Police, Airline or other Authority) Name

Were items lost/damaged by Carrier? (e.g. Airline) Yes ☐ No ☐ Name

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? If **Yes**, please provide details in the table below and attach copies of correspondence. If **No**, you should proceed to claim with your Carrier/Airline before submitting your claim to Allianz Global Assistance.

NOTE: The 1999 Montreal Convention imposes a liability upon Airlines and you should claim from them first.

Carrier	Claim no.

What action was taken to recover lost items?

Are any of the items covered by other insurance? Yes ☐ No ☐

If Yes - Which company Policy Number

Were all the missing articles owned by you? Yes ☐ No ☐

If not, give details

Full Details of Articles Claimed	Store From Where Item Was Originally Purchased	Original Date of Purchase	Original Purchase Price	Amount Claimed (NZD)	Proof of Purchase Attached?

E. Rental Vehicle Excess Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance.
2. Copy of your Rental Vehicle Agreement.
3. Copy of the Repair Invoice if claim is due to the Rental Vehicle being damaged.
4. Copy of documents showing amount debited to you by Rental Vehicle company for damage/excess.
5. Report made to the Police or other appropriate Authority.

Date and time of accident/incident / / Location of accident/incident

Rental Vehicle company name Country where the vehicle was rented:

Please state in full, exactly what happened for the claim to arise (if necessary, a diagram may be used to depict the event):

Was the damage due to a collision with another vehicle? Yes ☐ No ☐

If Yes, please provide the name and address of the person who was driving the other vehicle involved in the collision

Please provide the registration number of the other vehicle

Please provide the name and address of the insurer of the other vehicle:

Did police attend the incident? Yes ☐ No ☐ Was the accident/incident your fault? Yes ☐ No ☐

Repair costs Date the damage was paid for / /

Excess you were liable to pay Amount you are claiming for

Have you received compensation from any person or party involved in the accident or incident: Yes ☐ No ☐

If Yes, please state the amount received

F. Delayed Luggage Expenses Claim

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Copy of your Certificate of Insurance.
2. Itemised receipts for the purchase of Essential Items claimed by you.
3. Property Irregularity Report from the Carrier (ie. bus line, airline, shipping line or rail authority) and confirmation of any compensation paid to you.
4. Ticket and Baggage Tags from the Carrier who caused your luggage to be delayed.

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

Name of Carrier who delayed your luggage

Your arrival date / / Your arrival time am/pm

Date that your luggage was returned to you / / Time of return am/pm

What compensation was received from the carrier?

Please complete the below schedule in full. Claims will be converted to New Zealand dollars using the currency rate applicable at the date and time the expenses were incurred.

Description Of Essential Items Purchased	Date of Purchase	Price Paid	Store Where Item Was Purchased	Receipt Attached Yes/No
e.g. Woollen Jumper	e.g. 10/02/05	e.g. EUR 100	e.g. Benetton of London	e.g. Yes

G. Other

THE FOLLOWING DOCUMENTS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Certificate of Insurance.
2. Any other information in support of this claim.

Please tell us in as much detail as possible what happened to you in order for you to make this claim. Be as specific as possible, including dates and amounts paid. If there is not enough room in the space provided, you may continue your description of the events on a separate piece of paper.

Which Policy Benefit Section(s) do you believe to be the most applicable under which you can make this claim?

STEP 4 - PAYMENT DETAILS

Provide your bank details below for a direct credit to your nominated bank account. **Please note we cannot deposit into a credit card account.**

If we are required to make a payment on your behalf no payment will be made until we receive payment, from you, of any applicable excess.

Name of Bank

Branch: Account Holder

Bank Branch Account number Suffix

GST INFORMATION (ONLY APPLIES IF YOUR POLICY WAS PURCHASED FOR A BUSINESS).

Are you registered for GST Purposes? Yes ☐ No ☐

What is your New Zealand Company Number?

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 is being made? Yes ☐ No ☐

IF YES, what percentage of the GST did you claim or are you entitled to claim? %

(if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

CUSTOMER SERVICE QUESTIONNAIRE In order to ensure that the services we provide are maintained to the highest standards, we would appreciate a few moments of your time to complete a questionnaire. This will enable us to monitor our performance and implement any services which we feel would benefit our customers further. **Please confirm that you agree to receive a Questionnaire by Email ☐ (Please Tick)**

MEDICAL AUTHORITY AND DECLARATION

I DECLARE THAT:

- I will use my best endeavours and render all reasonable assistance and co-operation to Allianz Global Assistance in the assessment of my claim;
- The information supplied by me is true and correct and I have not withheld any information likely to affect the assessment of my claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proofs of my claim, Allianz Global Assistance has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy;
- A photocopy of this Authorisation shall be considered as effective and valid as the original and I specifically authorise its use as such.

I appoint Allianz Global Assistance to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as Allianz Global Assistance in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);
- my Health Insurance claims history;
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

Signature of Claimant | Date / /

Name of Claimant

Signature of Witness | Date / /

Name of Witness

Claim No: _____

Policy No: _____

Global Assistance

Allianz

Email: travelclaims@allianz-assistance.co.nz

MEDICAL CERTIFICATE

To be completed by the patient's usual Doctor/Dentist (at the claimant's expense) in all cases of cancellation and medical claims resulting from accident, sickness or death.

Name of person to whom this certificate applies (i.e. the person whose state of health caused the claim):

Date of Birth / /

Address

Postcode

Instructions to the Medical Professional:

Please complete this form in block letters, and provide as much information as possible, as this will accelerate this Travel Insurance claim.

1. **(a)** Are you the patient's usual medical practitioner? Yes ☐ No ☐ If **Yes**, for how long?

   (b) If **No**, do you have access to their medical records? Yes ☐ No ☐

The claimant must indicate (by ticking the relevant box) which is applicable, question 2 or 3.

☐ **2. Alteration to/cancellation of travel arrangements prior to travel.**

(a) Did you recommend that travel be cancelled or postponed due to the patient's state of health? Yes ☐ No ☐

(b) On what date did you make this recommendation? / /

(c) Please give precise details of the nature of the sickness or injury which gave rise to this recommendation (including the final diagnosis)

(d) Did you fully explain the risk of travelling with this medical condition? Yes ☐ No ☐

(e) On what date did the patient first become aware of their symptoms? / /

(f) Please describe the symptoms advised by the patient.

(g) On what date were you first made aware of the condition, or change in the condition? / /

(h) Has the patient previously been investigated, diagnosed or treated in respect to the same/similar/related sickness or injury? Yes ☐ No ☐

If **Yes**, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

(i) Did the patient make the travel arrangements against your advice (or the advice of another medical practitioner)? Yes ☐ No ☐

OR

☐ **3. Treatment costs/ additional expenses incurred during travel.**

(a) What do you understand to be the sickness or injury which resulted in the need to seek medical care/ interrupt the patient's travel plans?

(b) Has the patient previously been investigated, diagnosed or treated in respect to the same/similar/related sickness or injury? Yes ☐ No ☐

If **Yes**, please attach copies of all letters from referred specialists, including the patient's full medical history, current medications, all hospitalisations and emergency department visits in the last two (2) years.

(c) Was there any indication that medical care may be required on the journey?

(d) Was the patient non-compliant with medical advice whilst on the journey? Yes ☐ No ☐

(e) Did the patient travel against your advice (or the advice of another medical professional)? Yes ☐ No ☐

I certify that the statements contained in this Medical Certificate are true and correct.

Doctor's Signature

Date / /

Doctor's Stamp

Please post this form together with your claim form and all supporting documentation to Travel Claims Department, PO Box 210025, Laurence Stevens Drive, Manukau 2154 New Zealand

PLEASE NOTE: We cannot process your claim if you do not supply the listed documentation with your fully completed and signed claim form.