DUAL Corporate Travel Insurance

Claim Form

The issue of this form is not an admission of liability. All questions in this section must be answered

Checklist

- [ ] Completed claim form:
- [ ] Original Itinerary
- [ ] Replacement Itinerary
- [ ] Report or letter from Authority (e.g. Police, Airline)
- [ ] Proof of purchase of lost goods
- [ ] Original receipts and/or Tickets relating to additional expenses incurred
- [ ] Original Doctor's / Hospital accounts and receipts
- [ ] Original Doctor's Certificate
- [ ] Proof of cause i.e. Original Doctor's/Hospital's Certificate
- [ ] The Hire Car Agreement
- [ ] Hire Car Repair Invoice from the Hire Company
- [ ] Please see documents required under each section of the claim form.

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

Section 1 - Claimant Details

Name of Insured / Employer:

Policy Number:

Claimant Given Name and Family Name:

Occupation:

Date of birth:

Address:

Telephone No.:

Business No.:

Email:

Section 2 - Travel Information

Date of Departure: Date of Return / Expected Return:

Reason for Travel (ie. Business / Leisure / Business with Leisure:

Number of business travel days:

Number of leisure travel days:

Departure Country: Departure City:

Destination Country: Destination City:

Section 3 - Corporate Travel Authorisation

Name:

Position:

Company Name:

I hereby confirm that (Claimant Name) is an insured person and was on an approved business journey on the Date of Loss.

Signature:

Date:

Section 4 - Payee Bank Details

When the claim has been approved the payment will be credited direct to your Bank Account. Please complete the following:

Bank:

Swift code (for non Australian bank):

Account Name(s):

BSB Number:

Account Number:

GST Information (For Australian Claims Only)

a. Are you registered for GST Purposes? Yes ☐ No ☐

b. What is your Australian Business Number (ABN)?

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

Section 5 - Luggage And Personal Effects And Money (If Applicable)

Please give full details of how loss damage or theft occurred: (Detail each event)

Date of occurrence: Time: am / pm

Date loss reported: Time: am / pm

Loss reported to – Name:

Address:

Were articles lost by Carrier? (eg 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 so, please give details and attach copies of correspondence.

NOTE: The Warsaw Convention imposes a liability upon the Carrier and you should claim from them first.

Airline	Claim Number

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

If YES – which Company?

Were all the missing articles your property? Yes ☐ No ☐

If YES – who is the owner?

Description and size of suitcase in which missing goods carried:

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

Section 6 - Money (if applicable)

Date notified: To whom:

Which police were advised?

State Police Station and **attach a copy of the report** if available.

Description of the incident:

Details of claim:

The following items must be included with this claim*

1. Report or letter from Authority (e.g. Police, Airline) regarding the loss, where available.

2. 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 not possible to provide any of the supporting documents please advise the reason: (over page)

Section 7 - Medical Expenses, Medical Evacuation and Additional Expenses (if applicable)

Type of injury or sickness:

Date of accident or commencement of sickness:

Injury – give full details of accident:

Date of first medical consultation: Name of doctor or hospital:

Details of other treatment by Doctors/Hospital:

Dates in hospital: (Admitted) am / pm (Discharged) am / pm

Have you ever suffered from the same or a similar complaint in the past? Yes ☐ No ☐

If YES, give details, dates etc.:

Are you a member of a Private Health Insurance Fund e.g. Medibank? Yes ☐ No ☐

Name of Fund:

N.B. If you are a member of a Private Health Fund you must claim from that fund before submitting this claim.

The following items must be included with this claim:

1. Original Doctor's / Hospital accounts and receipts together with statements from Medicare and Private Health funds.

2. Original Doctor's Certificate.

*Failure to provide these items may result in delays in processing your claim. If it is not possible to provide any of the items please advise the reason:

Section 8 - Cancellation, Curtailment and Loss of Deposits (if applicable)

What was the reason you could not commence your proposed journey or complete the return flight:

Was the cancellation as a result of Injury/Sickness to yourself? Yes ☐ No ☐

Was the cancellation as a result of Injury/Sickness to some other relative or person as defined in the Policy? Yes ☐ No ☐

If YES, please provide details:

Name:

Address:

Relationship:

Age:

Nature of complaint preventing travel:

Date of first Medical Treatment:

Has the Injured / sick person had a similar condition in the past? Yes ☐ No ☐

Name and address of patient's normal Doctor:

Date you advised Travel Agent to cancel bookings:

Amount of Deposit paid $ Date paid:

Balance of Full Fare paid: $ Date paid:

Total paid: $

Refund received on cancellation: (excluding Insurance Premium) $

Were any alternative arrangements offered or made? (Give details)

Were any additional fares incurred as a result of cancellation: (Give details)

Section 9 - Cancellation, curtailment and loss of deposits - additional expenses (if applicable)

(Complete this section for additional expenses)

Reason for incurring additional expenses or forfeiting travel or Accommodation expenses:

Date of Expense	Details of Expenses	Amount Claimed (please state currency)

Were these expenses incurred as a result of Injury or Sickness as claimed on previous page? Yes ☐ No ☐

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.

Cause:

Name and Details:

The following items must be included with this claim:

1. Original receipts and/or Tickets relating to additional expenses incurred.

2. 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 items please advise the reason:

Section 10 - Accidental Death Claim (if applicable)

The following items must be included with this claim:

1. The Original Policy Document.

2. Original of the Death Certificate which will be returned to you.

3. Copy of Coroner's Depositions and Findings (if applicable)

4. Original Birth Certificate which will be returned to you.

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

What was the cause of death?

When did the accident occur? Date: Time: am / pm

Was a coronial inquest held or is one to be held? Yes ☐ No ☐

If YES, give details

Name and Address of usual family doctor:

How long has the doctor been known to the patient?

Section 11 - Hire Car Excess Claim (if applicable)

The following items must be included with this claim:

1. The Hire Car Agreement.
2. Notice from the Hire Car Company in respect of the excess or deductible.
3. Documentation evidencing payment of excess or deductible.
4. A copy of the Hire Car Repair Invoice from the Hire Company.

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

Please provide a full description of the circumstances of the incident giving rise to the claim:

Date of Incident	Rental Vehicle Excess (Currency)	Actual Repair Costs (Currency)	Amount Claimed

Should your claim not fall under any of the above, please contact Corporate Services Network (CSN) for further details and to discuss coverage.

Section 12 - Claim Lodgement Details

Please forward claim details using one of the following lodgement processes

(Please keep a copy of all documents sent to CSN)

Postal Address:

Corporate Services Network
GPO Box 4276
Sydney, NSW 2001

Email Address:

claims@csnet.com.au

Fax No:

+61 2 8256 1775

Phone Number:

Once the claim form has been completed, sent, and received by CSN, claim inquiries can be made to CSN on:
+61 (2) 8256 1770
Policy and coverage queries should first be directed to your Insurance Broker.

Privacy Collection Statement:

We are committed to protecting your privacy and complying with the *Privacy Act 1988* (Cth) ('Privacy Act').

We use your information to assess the risk of providing you with insurance, provide quotations, issue policies and assess and manage claims, on behalf of the insurers we represent. If you do not provide us with full information, we may not be able to provide insurance or assess and manage a claim. If you provide us with information about someone else, you must obtain their consent to do so.

We may provide your personal information to the insurer we represent, insurance regulators and other insurance bodies as required by law. We may also provide your information to your broker and any third party claims service providers (such as claims management companies, parties repairing or replacing the subject matter, loss adjusters and appointed law firms (and the like)). If a recipient is not regulated by laws which protect your information in a way that is similar to the Privacy Act, we will take reasonable steps to ensure that they protect your information in the same way we do or seek your consent before disclosing your information to them. We do not trade, rent or sell your information.

Our Privacy Policy contains more information about how to access and correct the information we hold about you and how to make a privacy related complaint, including how we will deal with it. By providing us with your personal information, you consent to its collection and use as outlined above and in our Privacy Policy. Ask us for a copy of our Privacy Policy via email at privacy@dualaustralia.com.au or access it via our website using the following link.

Declaration and Authorisation Complete for all Claims

I confirm and declare that:

- the information in this form and any documents attached to it, is correct and complete and that I have not withheld any information that could affect this claim. I understand that any false statements or information may lead to my claim being denied.
- I authorise any hospital, physician or other person who has attended to me to furnish the claims manager, Corporate Services Network (CSN), or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, including copies of all hospital or medical reports.
- should any information provided in this form alter after the date of this declaration, I will give immediate notice thereof to CSN.
- I agree that CSN and the Underwriters may use and disclose my personal information in accordance with the 'Privacy Collection Statement' found below.
- I agree that a photocopy of this declaration shall be considered as effective as the original.

Please print your name:

Your signature:

Date:

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