TRAVEL INSURANCE CLAIM FORM

Send your claim to: PO Box 5964, Brendale Q 4500
Email: claims@goinsurance.com.au | Fax: 07 3481 9899 | Call: 07 3481 9888

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1 A – YOUR DETAILS

Certificate number: _____

Title: | Given Name/s: | Surname: | Date of birth: __/__/____

Occupation: | Telephone: | Email:

Postal address: | Suburb: | State: | Postcode:

Has any claimant previously made any travel insurance claims? Y N
If yes, please provide details (including name of insurer, type of claim and settlement amount):

Has any claimant been in prison or convicted of any crime for attempting financial gain (i.e. fraud)? Y N
If yes, please provide details (including date and type of conviction/charge)

1 B – PREFERRED PAYMENT METHOD

Name of bank: | Branch: | Account holder/s name:

BSB number: ___-___ Account number: _____

Or please post me a cheque ☐

If your claim is accepted and you are entitled to receive a payment/s, we will credit the payment/s due to you directly to the Austalian bank account you have nominated above. Please ensure that the bank account details you provide to us are correct.

1 C - YOUR DECLARATION

I declare that all information in this claim form is true and correct. I acknowledge that my personal information may be disclosed to, and obtained from, certain parties (refer to privacy statement) as detailed in the combined Financial Services Guide and Product Disclosure Statement.

Signature of Claimant | Date __/__/____

WARNING: To avoid the costs of dishonest and fraudulent claims on to you, our honest policy holder, we are committed to investigating claims. We try to conduct investigations quickly and with minimal disruption. All cases of fraud will be reported to the Police and can result in prosecution.

2 A – ABOUT YOUR CLAIM

Where were you at the time? Town and Country (e.g. Manila/Philippines): | Location (e.g. café):

Date of incident: __/__/__ Time: __:__ AM PM

Briefly, what happened (e.g. my bag was stolen, I missed my flight, I was sick)? *If more space is required please attach separate page.*

Can you / have you claim/ed all or part of your loss through any other source or insurance? Y N If yes, please provide details:

2 B – CREDIT CARD INFORMATION

Some credit cards may provide LIMITED travel insurance cover in some circumstances. Did you purchase your travel arrangements on your credit card? Y N

If yes, please state:

Provider: e.g ABC Bank | Type: e.g. Gold Visa

Card Holder's Name:

3 – PARTICULARS OF YOUR CLAIM

Complete only the following sections that apply to your claim. If your claim does not fall into any of these categories, provide as much detail as possible in Section 4.

3 A – CANCELLATION, CURTAILMENT AND RESUMPTION OF TRAVEL

Date your trip was cancelled or curtailed ☐☐/☐☐/☐☐

Was your trip cancelled or curtailed due to your or / someone else's state of health? Y N *If no, please state the reason below:*

If it was not your state of health, please provide the following:

Name of person whose injury, illness or death caused the cancellation or curtailment:

Their relationship to you: | Their date of birth ☐☐/☐☐/☐☐ | Their normal country of residence:

Pre-Booked Arrangement	Cancellation costs a. Amount paid	b. Amount refunded by supplier	Amount Claimable (A minus B)
		-	=
		-	=
		-	=
		-	=
		-	=
		-	=
		-	=
		-	=

If you were able to amend your travel plans, please complete this table

Description	Original Cost	Cost to Amend

3 B – OVERSEAS MEDICAL AND DENTAL

Please describe your illness or injury. If your claim is due to an injury, please give a full description of the event & injury.

Were you hospitalised? Y N

Dates of Admission ☐☐/☐☐/☐☐ to ☐☐/☐☐/☐☐

Did you contact the Medical Assistance Team? Y N

Have you ever suffered from this condition before? Y N

Please list each bill / receipt seperately:

Name of doctor, dentist, pharmacy, hospital or provider	Date of treatment, consultation etc.	Amount charged (inc. currency)	Paid?
	☐☐/☐☐/☐☐		Y N
	☐☐/☐☐/☐☐		Y N
	☐☐/☐☐/☐☐		Y N
	☐☐/☐☐/☐☐		Y N

3 C – LUGGAGE AND MONEY

Date: Time: Country: Location

☐☐/☐☐/☐☐ ☐☐:☐☐ AM / PM

Please advise how the loss/theft/damage occured. If the incident occurred while the items were with you, please detail where the goods were placed in relation to your person at the time. *If more space is required please attach separate page.*

Were the Police or a responsible authority notified? Y N Report Reference Number

If No, please explain why this policy requirement was not met.

WARNING: Go Insurance takes fraud seriously. Fraud includes claiming for items you never owned, inflating the value of items you are claiming for, claiming for items that weren't lost, stolen or damaged or providing misleading or false information regarding the circumstances of loss. Go Insurance has a dedicated fraud team who thoroughly investigate all suspected cases of fraud and report to the Police both locally and overseas in the event a fraudulent police report has been filed. The cost of fraud increases the cost of travel insurance for all travellers.

Full Description of each item	Brand, model, number etc	Original purchase price & currency	Month & year of purchase	Proof of ownership attached?	Owner of this item
				☐	
				☐	
				☐	
				☐	

3 D – DELAYED LUGGAGE

Have you received compensation from the airline? Y N If yes, what was the compensation amount?

When did your flight arrive?

Date: Time:

☐☐/☐☐/☐☐ ☐☐:☐☐ AM / PM

Whan was your luggage returned to you?

Date: Time:

☐☐/☐☐/☐☐ ☐☐:☐☐ AM / PM

Description of items purchased	Price and currency	Description of items purchased	Price and currency
1.		3.	
2.		4.	

For the travellers(s) affected: How many bags did you check in? How many of these bags were delayed?

3 E – RENTAL CAR INSURANCE EXCESS

Date of incident: Time: Country: Location

☐☐/☐☐/☐☐ ☐☐:☐☐ AM / PM

Please advise how the accident/damage/theft occurred.

Did the damage occur whilst driving on an unsealed surface? Y N

Excess you were liable to pay

Repair costs

Amount you are claiming

Was there another party at fault? Y N

If yes, please provide the name and address of the at fault party as well as their insurance details if known.

4 – TRAVEL DISRUPTION & ADDITIONAL EXPENSES

Please complete this section if you are claiming for additional expenses which do not apply to any other section of the claim form.
Please provide details of what happened:

Description of cost	Amount claimed	Description of cost	Amount claimed
1.		4.	
2.		5.	
3.		6.	

If the above event had not occured, what were your original plans for this same time period?

Original Plan	Cost	Original Plan	Cost
1.		4.	
2.		5.	
3.		6.	

Were your original plans above pre-paid? Y N Partly paid Y N If your original plans were pre-paid, did you receive a refund? Y N

If yes, how much?

If your claim is due to travel delay:

When were you due to depart?
Date: Time:
☐☐/☐☐/☐☐ AM / PM

When did you actually depart?
Date: Time
☐☐/☐☐/☐☐ AM / PM

This section is for any other expenses not mentioned above.

Nature of expenses	Amount claimed	Nature of expenses	Amount claimed
1.		3.	
2.		4.	

Please forward relevant supporting documention to assist us in processing your claim. For more information, contact our claims team on 07 3481 9899

Medical Certification Form

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TERMS AND CONDITIONS

- This form must be completed by the usual doctor of the person whose state of health, injury or death has given rise to a Cancellation or Curtailment claim.
- **This form does not need to be completed for Medical Expenses claims, or if the trip was curtailed due to your state of health (unless specifically requested).**
- Any charges or fees incurred for the completion of this form must be paid for by the claimant and are not recoverable under the claim.
- **The original form must be posted to our office at PO Box 5964, Brendale, Qld, 4500.**
- **Faxed or scanned copies will not be accepted.**

IMPORTANT NOTICE TO DOCTORS: We respectfully request you answer the following questions with as much details as possible in order to assist with the assessment of the claim and to avoid the necessity of further queries.

POLICY INFORMATION

Certificate number: ☐☐☐☐☐☐☐☐☐☐

Name of claimant:

PATIENT DETAILS

Patient's full name:

Patient's address:

Suburb:

State:

Postcode:

Patient's date of birth: ☐☐/☐☐/☐☐

Patient's date of death (if applicable): ☐☐/☐☐/☐☐

Are you the patient's regular doctor? Y N

If yes, for how long? ☐☐ years ☐☐ months

PARTICULARS OF ILLNESS OR INJURY

Please provide a precise description of the illness or injury which has given rise to this claim:

When did the patient first become ill or sustain this injury? Date: ☐☐/☐☐/☐☐☐☐ Time: AM / PM

When were you first consulted for this illness or injury? Date: ☐☐/☐☐/☐☐☐☐ Time: AM / PM

Is the illness or injury caused by or traceable to a recurring or chronic illness or condition? Y N

If yes, please provide details below :

Has the patient suffered from the same or similar condition previously? Y N

If yes, please provide full history below :

Has the patient been awaiting / receiving tests, investigations or treatment for this or a related condition/s? Y N

If yes, please provide full details below, including relevant dates:

Please provide full details of any medication the patient has been prescribed, including dosage:

In the event of pregnancy please provide: The EDD ☐☐/☐☐/☐☐☐☐ The LMP ☐☐/☐☐/☐☐☐☐

Please describe any complications experienced in this or any prior pregnancy:

Do you consider the patient (if claimant) would have been fit to travel as planned? Y N

Did you advise the patient (if claimant) to cancel or curtail their scheduled trip? Y N

Your name:

Your signature:

Date signed: ☐☐/☐☐/☐☐

Your contact number:

ATTENTION DOCTORS: By completing and signing this form you declare that you have examined this patient and/or have referred to their medical records and confirm the information you have provided is true and correct.

If the patient is the claimant, please also provide a copy of their medical history and clinic notes (if applicable).