

## TRAVEL INSURANCE CLAIM FORM

Please print out for signatures and post original to your broker if applicable or American Home Assurance Company New Zealand branch (AHAC NZ) Box 1745, Auckland

- You will need to attach substantiating documents as specified in this claim form.
- Failure to provide substantiating items may result in delays in processing your claim – if it is impossible to provide any of the items required please advise the reason.
- The issue of this form is not an admission of liability and is without prejudice

### ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Full Policy No \_\_\_\_\_

Name of Traveller (Mr/Mrs/Miss/Ms) \_\_\_\_\_

Address: \_\_\_\_\_

Telephone – Home \_\_\_\_\_ Business \_\_\_\_\_ Email \_\_\_\_\_

Occupation \_\_\_\_\_ Date of Birth / / \_\_\_\_\_

Period of Journey: From / / to / /

**Settlement will be paid to the traveller unless the Policyholder specifically advises otherwise**

**PAYEE NAME:** \_\_\_\_\_

**Option 1: Direct credit to NZ bank account.** Please complete bank details and account number below

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**Option 2 Overseas Bank Transfer**

**BANK** \_\_\_\_\_ **BRANCH** \_\_\_\_\_ **COUNTRY** \_\_\_\_\_

**ACCOUNT DETAILS** \_\_\_\_\_

**OFFICE USE**

Bank a/c checked

**AHA no longer issues cheques. To confirm transfer of funds, an auto email will be sent to your broker or direct**

**Email: Broker / Payee** \_\_\_\_\_

**PAYEE SIGNATURE:** \_\_\_\_\_

### CORPORATE POLICIES: THE OFFICER AUTHORISED FOR POLICYHOLDER'S INSURANCE DECLARATIONS MUST COMPLETE THIS SECTION\*\*

**\*\*Are You the Company officer who is authorised to approve and responsible for all Travel Insurance declarations to the broker? YES / NO - If No refer to the authorised Company person to complete.**

Name of Insured Company \_\_\_\_\_

Traveller/claimant's position in Insured Company \_\_\_\_\_

Did the loss occur whilst on Authorised Business Travel? **YES / NO**

If YES, what was the nature of business to be done on the trip? \_\_\_\_\_

If NO, did you authorise cover under the Company policy for all the persons claiming loss? **YES / NO**

Has this trip been included on your annual travel insurance declaration? **YES / NO** When? \_\_\_\_\_

**Details of journey**

Departure Date / / Return Date / /

Was an air trip involved in the travel? **YES/NO** Give details \_\_\_\_\_

Signed \_\_\_\_\_ Date \_\_\_\_\_

Name (please print) \_\_\_\_\_ Position \_\_\_\_\_

**NB: Settlement will be paid to the Traveller unless the Policyholder specifically instructs AHA otherwise.**

**THE FOLLOWING SECTIONS TO BE COMPLETED BY THE CLAIMANT**



## Section 2 – Medical Expenses or Cash in Hospital

Date of Accident or Date Symptoms of Sickness First Appeared \_\_\_\_/\_\_\_\_/\_\_\_\_

Where were you ?

Place:

Town/City :

Country:

Give full details of Injury or Illness \_\_\_\_\_

Have you Lodged a claim with ACC? **YES/NO** Advise their claim number \_\_\_\_\_

Date of First Medical Consultation \_\_\_\_/\_\_\_\_/\_\_\_\_ Name & Address of Doctor or Hospital \_\_\_\_\_

Name & Address of any other Doctor/s Hospital/s who treated You \_\_\_\_\_

Hospital: Date 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, duration etc. \_\_\_\_\_

**NB. If you are a member of a Private Health fund you must claim from that fund before submitting this claim.**

Are you a member of a Private Health Insurance fund e.g. Southern Cross **YES/NO** Name of Insurer \_\_\_\_\_

**THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM**

1. Original Doctors/Hospital accounts and receipts together with statements from your Private Health Insurer/ACC details.
2. Original Doctors Certificate.

## Section 3 – Cancellation/Additional Expenses

Cancellation of journey:

Please give reason \_\_\_\_\_

Date you advised Travel Agent to cancel bookings \_\_\_\_/\_\_\_\_/\_\_\_\_

If cancellation costs or additional expenses were incurred due to Injury/Sickness:

Name of person \_\_\_\_\_ Relationship to You \_\_\_\_\_

Address \_\_\_\_\_ Age \_\_\_\_\_

Describe the Injury/Illness \_\_\_\_\_

Date of First Treatment \_\_\_\_/\_\_\_\_/\_\_\_\_ Has the Injured/Sick person had a similar condition before? **YES/NO**

Patients Usual Doctor Name and Address \_\_\_\_\_

Amount of Deposit paid \$ \_\_\_\_\_ Date Paid \_\_\_\_/\_\_\_\_/\_\_\_\_

Balance of Full Fare paid \$ \_\_\_\_\_ Date paid \_\_\_\_/\_\_\_\_/\_\_\_\_

TOTAL PAID \$ \_\_\_\_\_ LESS Refund on cancellation (\$ \_\_\_\_\_ ) Date Received \_\_\_\_/\_\_\_\_/\_\_\_\_

Were any additional fares incurred as a result of cancellation **YES/NO Give Details** \_\_\_\_\_

Were any alternative arrangements sought by You or alternative offers made? **YES/NO** (Give details) \_\_\_\_\_

Reason for incurring additional expenses or forfeiting travel or Accommodation expenses \_\_\_\_\_

Details of expenses incurred (attach list if required) <b>Description of Item</b>	<b>Cost NZ\$</b>
<b>TOTAL</b>	<b>NZ\$</b>

**THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM**

- Original Receipts and/or Tickets relating to loss of deposits or additional expenses incurred
- Substantiation i.e. Original Doctor/Hospitals Certificate relating to Injured or Sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport.

## Section 4 – Personal Money

Date of Loss \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Place of loss \_\_\_\_\_

Date Notified \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Which Police Station was advised? \_\_\_\_\_

Amount Claimed \$ \_\_\_\_\_ Attach copy report if available \_\_\_\_\_

Description of the incident \_\_\_\_\_

## Section 5 – Personal Liability

### Bodily Injury

Name and Address of Injured Party \_\_\_\_\_

Details of injury \_\_\_\_\_

Is the Injury or Damage related to a travelling companion? **YES/NO** Is this person related to You? **YES/NO** Give details \_\_\_\_\_

### Damage to Third Party Property

Name and Address of Party claiming against You \_\_\_\_\_

Describe Property Damage \_\_\_\_\_

Do you consider you were at fault? **YES / NO** (If yes, why) \_\_\_\_\_

- **Letters or Demands of a claim made on you MUST BE INCLUDED WITH THIS CLAIM**

## Section 6 – Declaration; Authority & Privacy Consent INSURED TRAVELLER MUST SIGN BELOW

I/we print names \_\_\_\_\_  
declare that the above answers and those contained in any attachments are true and note that the Insurer may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to provide American Home Assurance Company (New Zealand Branch) ('AHAC NZ') with assistance in dealing with this matter and understand that failure to co-operate with AHAC NZ and to provide all information relevant to the circumstance may result in my/our claim being denied.

### AUTHORITY:

I/we authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish AHAC NZ or its representatives with:

- copies of hospital and medical reports/notes;
- copies of employment records and income tax returns; to the extent that they are relevant to the claim and
- information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

I/we agree that a photocopy of this authorisation shall be considered as effective and valid as the original and authorise its use as such.

### PRIVACY:

I/we consent to AHAC NZ in accordance with the *Privacy Act 1993*:

- collecting holding and using personal information including information by audio, photographic or video surveillance, provided for purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
- disclosing personal information submitted to another member of the AIG group of companies in New Zealand or overseas, their staff members located outside New Zealand, the insured, other insurers and re-insurers, law enforcement agencies, investigators, lawyers, assessors, advisors and the agent of any of these, insurance broker, insurance agent or intermediary, employer for the purpose of administering my claim or providing a report.

Information is provided voluntarily however if we do not collect this information we may not be able to assess a claim. Insured persons have rights of access and correction to their personal information under the Privacy Act. Further information about this or making a privacy complaint can be obtained by emailing : [Privacy.officerNZ@aig.com](mailto:Privacy.officerNZ@aig.com)

NOTE: AHAC NZ will only seek information which in its opinion it believes to be relevant to investigation of the claim

Signature/s of Insured person/s \_\_\_\_\_

Date: \_\_\_\_ / \_\_\_\_ / \_\_\_\_