

# 1

**THESE SECTIONS MUST BE COMPLETED TOGETHER WITH THE SECTIONS ON THE FOLLOWING PAGES THAT APPLY TO YOUR CLAIM.**

Insured's Surname	Given Name/s	Age
<input type="text"/>	<input type="text"/>	<input type="text"/>
Insured's Permanent Postal Address		
<input type="text"/>		
<input type="text"/>		
Home	Business	Mobile
<input type="text"/>	<input type="text"/>	<input type="text"/>

# 2

Policy Number (please attach policy certificate)	Occupation	
<input type="text"/>	<input type="text"/>	
Travel Agent	Travel Agent's Telephone Number	
<input type="text"/>	<input type="text"/>	
Date Travel Commenced	Destination	Date Returned
<input type="text"/>	<input type="text"/>	<input type="text"/>
Do you hold a policy with any other company indemnifying you in respect of this accident/loss? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, state name of company and policy details		
<input type="text"/>		
<input type="text"/>		
Have you ever made a travel insurance claim of any nature with any insurance company? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, please state the insurer, date and reason for the claim, amount claimed etc.		
<input type="text"/>		
<input type="text"/>		

# 3

## PLEASE READ THIS IMPORTANT INFORMATION CAREFULLY

If you require further information please phone our Claims Department on (08) 9265 6402.

### DECLARATION

I/We declare that:

1. The information contained in this claim form is true and complete in every respect, and I have not withheld any relevant information.
2. HBF Insurance is authorised to obtain any statement made in relation to this claim form from the Police and any particulars in relation to any criminal convictions.
3. HBF may lawfully refuse to pay this claim if fraudulent information is included in this claim or material facts have been fraudulently concealed or omitted.
4. I consent to HBF Insurance disclosing my personal information to other insurers, an insurance reference service or as required by law. I consent to HBF Insurance also disclosing my personal information to and/or collecting additional information about me, from investigators or legal advisors.

### MEDICAL AUTHORITY

With regard to MEDICAL EXPENSES/CANCELLATION/ADDITIONAL EXPENDITURE claims, I hereby authorise any hospital, physician or other person who has attended me to furnish to HBF Insurance Pty Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all hospital or medical records. I agree that a photocopy of this authorisation shall be considered as effective and valid as the original.

### FURTHERMORE

In consideration of HBF Insurance Pty Ltd on behalf of the Insurers agreeing to meet payment of this claim, I/we hereby agree to discharge HBF Insurance Pty Ltd and the Insurers from any further liability, claims or demands in respect of this claim. Any property which is subject of this claim will be owned by the Insurer by virtue of the claim having been settled in respect of such property.

Signature	Date
<input type="text"/>	<input type="text"/>

1

Surname of Person Treated

Given Name/s

Age

Date of injury/illness

D	D	M	M	Y	Y
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Explain incident resulting in a claim




2

Name of Doctor/Hospital

Address of Doctor/Hospital

If hospitalised, did you contact our Worldwide Emergency Assistance?  Yes  No

If no, why not?

Was this illness relating to a pre-existing condition evident prior to travel?  Yes  No

If yes, please clarify

Was approval given for cover of the pre-existing condition(s) by HBF Insurance in your application for insurance?  Yes  No

If yes, please state your approval number

Are you a member of a health insurance fund?  Yes  No

If yes, please obtain any entitlement from this fund (hospitalisation, dental, optical, physiotherapy benefit etc).

**An excess may apply to your claim. Please refer to your policy wording or contact us on 133 423.**

3

### OVERSEAS MEDICAL, HOSPITAL AND DENTAL EXPENSES

Attach all original accounts and original receipts for treatment received, eg hospitalisation, surgery, etc.

Proof of payment may also be required to support receipts.

Insured's name	Provider's name	Date of service/s	Diagnosis and treatment received	Amount paid by you (in foreign currency)

**Conversion rate used is the rate applicable at the time of the assessment.**



## 1

**YOU MUST ANSWER ALL QUESTIONS AND ATTACH THE FOLLOWING DOCUMENTS**

(photocopies are not acceptable – originals must be provided):

- Police report (plus English translation where applicable).
- Lost baggage report from any other authorities (plus English translation where applicable).
- Proof of ownership and value of the missing items (receipts, credit card vouchers, guarantee or warranty cards, or statements or valuations obtained prior to the loss).

Is the claim for:  Loss  Theft  Damage  Delayed luggage  Vehicle hire excess

Country and place where loss occurred

Date of loss/damage

Time

 am/pm

Place that lost property was last seen

Date that lost property was last seen

Time

 am/pm

## 2

Describe in full detail how the loss or damage occurred.

What action did you take to recover the lost items and minimise the loss?

Which authority (eg police, airline, hotel) did you notify regarding the incident?

Give details of time and date of notification and ensure that the written report is attached.

Were the articles the subject of this claim otherwise insured?  Yes  No

If yes, state name of insurer?

Policy Number

**Please note that receipts for the items lost must be submitted for proof of ownership and value of items claimed. An excess may apply to your claim. Please refer to your policy wording or contact us on 133 423.**

## 3

Full description of the article/s claimed	Date & place of original purchase	Original cost price

**If insufficient space provided, please attach separate list. Conversion rate used is the rate applicable at the time of the assessment.**

# Cancellation/Curtailment or Delay



1

**PLEASE APPLY TO YOUR TRAVEL AGENT FOR ALL REFUNDS AVAILABLE FOR YOUR CANCELLED TRAVEL ARRANGEMENTS. YOU MUST ALSO SUPPLY YOUR TRAVEL AGENT'S WRITTEN RESPONSE WITH THIS CLAIM.**

Place where claim occurred

Date

D	D	M	M	Y	Y
---	---	---	---	---	---

Time

0	0	:	0	0
---	---	---	---	---

 am/pm

Explain incident resulting in a claim


2

Have you incurred loss of pre-booked expenses?  Yes  No

If yes, please complete the following:

List loss of expenses (eg accommodation/tickets/tours)	Amount Paid	Amount Refunded	Balance Claimed
Amount Claimed			\$

3

Have you incurred any additional expenses following cancellation of your pre-booked expenses?  Yes  No

If yes, please complete the following:

List of additional expenses (eg accommodation/tickets/transport etc)	Amount Paid
Amount Claimed	

(Please attach receipts) Pre-Booked Expenses	\$
Additional Expenses	\$
TOTAL	\$

**An excess may apply to your claim. Please refer to your policy wording or contact us on 133 423.**