Agile

Corporate Travel Insurance

Claims form

Issued by Agile Underwriting Services Pty Ltd
ABN 48 607 908 243 — AFSL 483374

Powered by Agile

LLOYD'S Underwriters

Important Information

- Please complete all relevant sections of this claim form and provide any supporting documentation to ensure prompt payment of your claim
- This clam form can be completed and sent electronically. Alternatively you can manually complete this claim form and email it to ahclaims@withagile.com
- We take your privacy very seriously. If you would like to review our Privacy Policy you can call us on 1300 705 031 or email us at privacy@withagile.com or visit our website www.withagile.com
- Refer to the checklist to make sure you have provided all necessary documentation for your claim

Checklist

- ☐ Medical certificate
- ☐ Medical reports
- ☐ Hospital admission/discharge documents
- ☐ Receipts/Invoices
- ☐ Police report
- ☐ Flight/travel documents
- ☐ Completed all relevant sections of this claim form
- ☐ All original supporting documentation has been provided
- ☐ You have signed this claim form

Section 1 – Policy Details

Policy Number:	Expiry Date: / /	Member Number (if applicable):
Name of Insurance Broker (if applicable):	Name of Insured Company:	

Section 2 – Personal Details

Title:	Given Name(s)	Gender: Male ☐ Female ☐
Family Name:		Date of birth: / /

Contact details:

Street Address:

City:	State:	Postcode:

Telephone number:	Alternative Contact Number:	Email address:

Section 3 – Travel Details

Dates of travel:	Departure Date: / /	Return Date: / /

Departure Location:	Departure City:	Departure Country:
Destination Location:	Destination City:	Destination Country:
Reason for Travel:	☐ Business/Work ☐ Other (please provide details): ☐ Holiday ☐ Combination	

Section 4 – Claim Details

Please provide details about the incident.	Date of Incident: / /	Time of Incident: (24-hour clock) :

Place of Incident:	Incident City:	Incident Country:

Please provide details about the accident / damage / theft / sickness / injury that occurred:

Section 5 – Medical Expenses

(complete if applicable)

- Please only complete this section if the event occurred after the commencement of the trip
- Medical receipts will need to be provided with this section
- We reserve the right to obtain medical history/details of the claimant, or the person whose accident, sickness or accidental death necessitates the curtailment of the journey
- All medical and hospital accounts incurred within Australia must first be submitted to Medicare for refund and if applicable your private health fund

Was Fullerton's Health Assistance contacted?	Yes ☐ No ☐
If due to a sickness, have you suffered this complaint before?	Yes ☐ No ☐ N/A ☐

Please provide details of the Medical and/or Hospital Expenses (use separate sheet if insufficient space):

Date of Expense:	Medical/Hospital Expenses Details:	Amount ($AUD):
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$
/ /		$

Section 6 – Lost, Stolen or Damaged Baggage and Personal Effects

(complete if applicable)

- If the loss or damage occurred whilst in the care of a carrier (airline, bus company, etc.), the carrier must be notified, and a Property Irregularity Report must be submitted with this claim form
- Article Details Statement needs to be fully completed and supporting documentation (including receipts, valuation, certificates, credit/debit card statements, photo's etc.) must be submitted with this claim form
- If an article is damaged beyond economic repair, written confirmation from a competent repairer or dealer must be submitted with this claim form
- If an article can be repaired, a written estimate for repair (where practical), should be submitted with this claim form
- Any optical expenses must be first submitted to your health fund (if applicable)
- Lost/Stolen goods must be reported to the Police and a Police report must be submitted with this claim form
- **The Warsaw Convention and The Montreal Conventions imposes a liability upon the carrier, and if applicable you should claim against them in the first instance**

Was the incident reported to the Airline?	☐ Yes ☐ No ☐ N/A	If yes, please provide report / incident number:

Was the incident reported to the Police or any other authority? Yes ☐ No ☐ N/A ☐

If yes, please provide report / incident number:	If No, please provide explanation:

Were articles lost or damaged by a carrier? Yes ☐ No ☐

Were all lost or damaged articles your property? Yes ☐ No ☐

If No, who is the owner?

Have you lodged a claim or complaint against any carrier or other authority or individual responsible for the loss or damage to your property? Yes ☐ No ☐

If Yes, please provide details and supporting documentation:

If No, please provide an explanation

If you are claiming for spectacles, dentures and/or hearing aids, are these covered by your private health fund? Yes ☐ No ☐

If Yes, please complete the following:

Name of fund:	Membership Number:
Amount paid by private health fund:	Currency:

Was your luggage delayed? Yes ☐ No ☐

If Yes, please complete the following:		Compensation paid by carrier: $	Currency:
Your arrival date: / /	Time (24-hour clock): :	Luggage arrival date: / /	Time (24-hour clock): :

Article Details Statement

Please provide a full description of the article(s) lost or damaged and specific details of the damage where applicable. Please provide any relevant supporting documentation (receipts, valuation, certificates, photo's, credit/debit card statements, etc.) with your claim. **Attach separate sheet if insufficient room.**

Description of article(s) and details of damage if applicable:	Original price of article ($AUD):	Date / place of purchase:	Has item been replaced:	Amount being claimed ($AUD):
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$
	$		Y ☐ N ☐	$

Section 7 – Additional and/or Forfeited Expenses (complete if applicable)

- Please only complete this section if the event occurred after the commencement of the trip
- Only original accounts and/or receipts for accommodation and transport costs will be accepted
- If claiming for additional expenses, either a Medical Certificate or the Medical Certificate located in this claim form, from the doctor or specialist who treated you must be provided to support any change of travel plans due to an accident, sickness or death

If you are claiming for additional expenses, what were your original travel plans including your transport and accommodation and how were they changed?

Date of Expense:	Additional transport and/or accommodation expenses (please provide full details).	Amount being claimed ($AUD):
/ /		$
/ /		$
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Date of Expense:	Forfeited expenses (please provide full details):	Amount being claimed ($AUD):
/ /		$
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/ /		$
/ /		$

Section 8 – Hire Car Expenses

(complete if applicable)

- A copy of the hire vehicle agreement must be submitted with this claim form
- Please ensure that any damage report and/or repair invoice is submitted with this claim form

What vehicle did you hire?	☐ Car ☐ Van ☐ Truck ☐ Other
Name of vehicle hire company:	
Drivers full name:	
Valid driver's licence:	Yes ☐ No ☐

Rental vehicle excess:	$	Currency:
Actual repair cost:	$	Currency:
Amount you are claiming:	$	Currency:

Details of incident:

Section 9 – Loss of Deposits / Cancellation Expenses (complete if applicable)

- If you are claiming trip cancellation which occurred prior to your departure, as a result of injury, sickness or death, you must either provide a Medical Certificate or the Medical Certificate located in this claim form, from the doctor or specialist who treated the person whose state of health resulted in the claim
- We reserve the right to obtain medical history/details of the claimant, or the person whose accident, sickness or accidental death necessitates the curtailment of the journey
- Supporting documentation from the carrier/travel provider, showing any cancellation charges must be submitted with this claim form

Date travel arrangements were booked / /	**Date of cancellation:** / /

Please provide the reason for cancellation:

If cancellation is due to accident, sickness or death, please provide the persons details.
If cancellation is due to a death, please submit death certificate with this claim form.

Title:	Given Name(s):	Family Name:
Relationship of person to claimant:		

Amount Paid:	$	Currency:
Amount Refunded:	$	Currency:
Amount Claiming:	$	Currency:

If there is no refund, please state the reason why (you must obtain all refunds possible):

Declaration

I/we the undersigned duly authorised person(s) declare that:

i) I am/we are authorised by each of the Insured to sign this Claim Form; and
ii) the above statements are correct, true and complete; and
iii) no information material to this Claim Form has been withheld; and
iv) I/we have read the important information which you have put before me/us; and
v) I/we understand that no claim will be paid until such time as the insurer has confirmed acceptance of the claim form and attaching documentation; and
vi) I/we undertake to inform the insurer of any material alteration to these facts occurring before acceptance of the claim; and
vii) I/we acknowledge that the insurer relies on the information and representations in this Claim Form and otherwise made by me/us in relation to this claim; and
viii) except where indicated to the contrary, I/we understand that any statement made in this Claim Form will be treated by the insurer as a statement made by all persons making a claim; and
ix) I/we have read Agile's Privacy Statement on this Claim Form, and consent to the use, disclosure and obtaining of personal information about the Insured for the purposes shown in the Privacy Statement.

Name of Claimant:	Signature of Claimant:	Date: (DD/MM/YY) / /

Medical Certificate

Patients Details

Title:	Given Name(s):	Family Name:	Date of birth: / /

History

Are you his/her usual medical attendant? Yes ☐ No ☐

If Yes, for how long?	Days:	Months:	Years:

Please provide details with respect to the injury or sickness:

Start date of injury or sickness:			/ /
State the date on which you were first consulted in relation to the condition described above:			/ /
In your opinion, how long has the condition been present prior to consultation:	Days:	Months:	Years:
Are you able to determine, that solely based on the condition as describe above, your patient (the claimant) was compelled to cancel the travel arrangements?			Yes ☐ No ☐

What treatment, if any, has your patient (the claimant) previously received for this or any other related condition, and when was treatment received?

Is he/she suffering from any chronic disease or sickness or from any physical defect or infirmity?

If the claim is as a result of death, in your opinion, was it sudden and unexpected?

Yes ☐ No ☐

If yes, please provide details:

Declaration

Name:	Qualification:

Street Address:

City:	State:	Postcode:

Email address:

Contact Number:	Signature:	Date: (DD/MM/YY) / /