FREQUENT FLYER | QANTAS INSURANCE

Making a claim with your policy

What you need to do:

- It's important that you complete all the relevant sections of this form with as much detail as you can. You can find a list of documents required under each section.
- Before submitting your claim, please refer to your policy wording and Certificate of Insurance for any excesses, limits, exclusions or conditions of cover which may apply.
- Sign the declaration, fill in your bank details on pg. 9 and send your completed form to us through either;

Email:

travel-claims@nib.com.au

Postal Address:

Travel Claims Department
PO Box A975
Sydney, NSW 1235
Australia

Need some help?

Phone: 1300 783 146 or +61 2 8256 1514

1. You & your policy

Your Policy

1. **Certificate of Insurance / Policy Number:**

Did you contact nib International Assistance?

☐ No › Go to Question 2

☐ Yes › Give details below

Please enter your assistance reference number:

Your Details:

2. **Title:** **First Name:**
3. **Last Name:**
4. **Date of birth:** (DD/MM/YYYY)
   / /
5. **Preferred contact number:**
6. **Email Address:**
7. **Address:**

State/region **Postcode**

Nominated Authority

Please note: we may not be able to disclose information relating to this claim to anyone other than the claimant unless provided the authority to do so.

I (claimant) authorise the following person to act on my behalf in respect to this claim and to be provided with information, including personal information, relating to this claim.

Individual to act as Nominated Authority:

Their date of birth: (DD/MM/YYYY)

/ /

Address:

Email:

State/region **Postcode**

Preferred contact number:

2. Tell us what happened

Please provide an exact description of the events that caused you to make this claim.

When?

Date and time you were first aware of the loss, incident or need to change or cancel your trip:

(DD/MM/YYYY) ☐ / ☐ / ☐ (HH:MM) ☐ : ☐ (AM/PM) ☐

Where?

Town and Country (e.g. Paris/France): ☐

Location (e.g. Hotel Reception): ☐

What happened?

Please give a detailed account of what happened, how the incident occurred and how it impacted your trip

☐

Information about your trip

1. **When was your first booking?** (DD/MM/YYYY) ☐ / ☐ / ☐
2. **When was the first payment for your trip?** (DD/MM/YYYY) ☐ / ☐ / ☐
3. **When was the last payment for your trip?** (DD/MM/YYYY) ☐ / ☐ / ☐
4. **Were you travelling for:**
   ☐ Holiday ☐ Business

For all claims we need your

☐ Proof of your travel dates (e.g. eTickets)
☐ Relevant Credit Card Statements where used to purchase travel arrangements

5. **If you have an Australian business that is registered for goods and services tax (GST), you may be eligible to claim GST on your premium as an input tax credit (ITC). Have you or do you intend to claim GST on your premium as an input tax credit?**
   ☐ No ☐ Yes
6. **If yes, please specify business use %:** ☐
7. **If you purchased any of your travel arrangements on your credit card please give details:**

   Credit Card Provider (e.g. National Australia Bank)**:** ☐

   Card Type:
   ☐ Visa ☐ Mastercard ☐ Amex ☐ Other

   Card Level:
   ☐ Standard ☐ Gold ☐ Platinum ☐ Other

   If other please specify in the box below: ☐

3. What are you claiming for?

The next part of this form is divided into specific sections relevant to different claim types. Please complete only the section(s) applicable to your claim. Specific documents will also be required to support your claim, the Checklists under each section will help guide you.

3a - Trip Cancellation or Change/Trip Amendment/Additional or Other Expenses

Details of Cancellation or Change

1. **Was the cancellation/change due to illness, injury or death?**

☐ Yes › Go to Question 2

☐ No › Please advise reason:

2. **If cancellation/change was caused by a person please provide the following:**
Name of person causing the trip to be cancelled:

Relationship to you:

3. **Name of all people whose arrangements have been cancelled/affected:**

4. **Date Agent/Airline Notified** (DD/MM/YYYY)
/ /

Please note: If cancellation was caused by death, injury or illness you must also complete Step 3e.

If your trip was changed or postponed:

5. **Total cancellation fee if trip was cancelled outright:**
$

6. **Additional amount paid:**
$

7. **Date trip was rebooked** (DD/MM/YYYY)
/ /

If you lost Reward Points

8. **Total amount of points used to purchase air ticket:**

9. **Did you pay any additional amount towards this air ticket?**
☐ Yes ☐ No
$

10. **Total amount of points refunded:**

11. **Total amount of points lost:**

12. **Date trip was rebooked** (DD/MM/YYYY)
/ /

Documents Required

- ☐ Booking conditions showing breakdown of all trip costs
- ☐ Documents confirming refunds provided by travel agency, tour company, airline, etc
- ☐ Proof of payment for expenses paid by you (eg. receipts, credit card/ bank statements showing payments made)
- ☐ Completed Medical or Death Certificate (where claim was due to medical reasons)
- ☐ Evidence of circumstances which impacted your trip (eg, Letter from Transport Provider explaining the circumstances of the cancellation/refund/ compensation, letter from employer)
- ☐ Airline tickets (including cost and points used)

Additional Documents - Loss of Reward Points

- ☐ Reward statement showing total points used, any points charged as cancellation & any refund of points

Additional Documents - Additional or Other Expenses

- ☐ Evidence from the provider (Airline, Hotel, Bus company) explaining the circumstances of the expenses

Additional Documents - Resumption of Trip

- ☐ Revised booking confirmation, itinerary and invoice showing original and new booking
- ☐ Copy of return ticket used and unused
- ☐ Cancellation fees that would have applied had the original trip been cancelled in full

3b - Luggage and Personal Effects

Your luggage includes your clothing and other personal belongings, including travel documents and things you buy during your trip.
Please note: as per your Product Disclosure Statement, some items may be subject to depreciation.

1. **Are you claiming for:**
   ☐ Loss ☐ Theft ☐ Damage ☐ Delayed
2. **Date and time Loss/Theft/Damage/Delay was discovered:**
   (DD/MM/YYYY) (HH:MM) (AM/PM)
   / / :
3. **Who was it reported to?**
   ☐ Police ☐ Airline/Carrier ☐ Tour Guide
   ☐ Hotel Management ☐ Other ☐ Not Reported
   If other please give details below:
4. **Name of police officer or relevant authority:**
5. **Job title/position:**
6. **Location:**
7. **Report number:**
8. **Date and time reported:**
   (DD/MM/YYYY) (HH:MM) (AM/PM)
   / / :
9. **If not reported, please explain why**
10. **Have you claimed against your household insurance policy/private health fund for any of the items?**
    ☐ No – not reported
    ☐ Yes – No cover available › Give details below
    ☐ Yes – Cover provided › Give details below
    Name of insurer/fund:
    Policy/Member number:
    Amount paid by insurer/fund:
    $

If your Luggage and Personal Effects were delayed

1. **Your arrival date and time at destination:**
   (DD/MM/YYYY) (HH:MM) (AM/PM)
   / / :
2. **Date and time your luggage arrived:**
   (DD/MM/YYYY) (HH:MM) (AM/PM)
   / / :
3. **Have you made a claim against your carrier?**
   ☐ No
   ☐ Yes › What compensation did the carrier pay you?
   Amount: **Currency:**

Please note: if your luggage is delayed, lost or damaged while in the care of the carrier, they may have a responsibility to compensate you. It is therefore essential that you first claim compensation from the carrier and obtain and provide us with written confirmation of their response to your claim.

Documents Required

☐ Proof of ownership of all items
☐ Repair quotes for damaged items
☐ Copy of notification to relevant authority made once loss, theft, damage or delay noticed (e,g. Carrier property irregularity report (PIR), Police Report, etc.)
☐ Original receipts for replacement items
☐ Boarding pass & baggage tags from the carrier ATM, bank, credit card statement or currency conversion slips showing withdrawal of funds
☐ Proof that IMEI number locked for mobile phones

Additional Documents – Replacement of Travel Documents

☐ Receipts or invoice of original travel documents
☐ Receipts relating to the replacement of travel documents

Additional Documents – Delayed Luggage

☐ Proof of purchase for essential items

3c - Rental Vehicle Insurance Excess

1. **Name of vehicle hire company:**
2. **Name of person driving the vehicle:**
3. **Their date of birth:** (DD/MM/YYYY)
   / /
4. **Rental vehicle excess:** **Currency:**
5. **Actual repair costs:** **Currency:**
6. **Amount you are claiming:** **Currency:**
7. **Charge to return vehicle if unfit to drive:** **Currency:**

Documents Required

☐ Rental vehicle agreement showing the excess you are liable for
☐ Receipts for excess payment
☐ Copy of Driver's License (front & back)
☐ Credit card statement showing payment of the excess
☐ Copy of repair quote/account
☐ Copy of rental vehicle accident/incident report

3d - Medical and Dental Expenses

1. **Name of ill/injured person:**
2. **Their date of birth:** (DD/MM/YYYY)
   / /
3. **Relationship to you (if not you):**
4. **Nature of illness/injury**
5. **Date first occurred:** (DD/MM/YYYY)
   / /
6. **Name and address of Doctor/Dentist who treated illness/injury:**
7. **Place where Illness/Injury was treated:**
8. **Were they admitted to hospital?**
   ☐ Yes ☐ No
9. **Date and time admitted:**
   (DD/MM/YYYY) (HH:MM) (AM/PM)
   / / :
10. **Date and time discharged:**
    (DD/MM/YYYY) (HH:MM) (AM/PM)
    / / :
11. **Are you claiming for loss of income due to illness or injury?**
    ☐ Yes. Go to question 12 ☐ No
12. **Date due to return to work:**
    (DD/MM/YYYY) (HH:MM) (AM/PM)
    / / :

Documents Required – Medical and Dental Expenses

☐ General Practitioner/Dentist Medical Certificate (p6) Original medical/dental receipts
☐ Treating doctors report
☐ Hospital admission and discharge reports where relevant
☐ Letter from dentist with details of emergency treatment provided

Documents Required – Loss of Income (Due to Injury)

☐ Doctors report detailing period unfit to work
☐ Centrelink advice of payment if you have an entitlement
☐ Written confirmation from your employer of the date you were scheduled to return to work
☐ Pay slips for the 6 months prior to the departure of your trip (to allow us to confirm your average pay)

3e - General Practitioner/Dentist Medical Certificate

(Part 1) – To be completed by the person whose condition caused the claim, their legal guardian, Executor of Estate or a party with the appropriate Power of Attorney

Please note: proof of Power of Attorney or Executor of Estate would need to be provided for us to acknowledge this authority.

Medical Authority: I authorise any hospital, physician or other person who has attended me, to give my travel insurance company or its representative any, or all, information with respect to the condition which has given rise to this claim, including but not limited to, consultation history, prescription records, specialist records and hospital records. I agree that a photocopy of this authorisation will be considered as effective and valid as the original and understand that any information supplied to my travel insurance company may be disclosed to the claimant or a person who has been authorised to act on behalf of the claimant in relation to this claim.

Name of the person whose illness or injury caused the claim:

Their date of birth: (DD/MM/YYYY)

/ /

Name of legal guardian or Executor (if applicable)**:**

Signature:

Date of signature: (DD/MM/YYYY)

/ /

Contact details of the General Practitioner:

(Part 2) - To be completed by your usual General Practitioner/Dentist

This Medical Certificate must be completed at the claimant's expense by the usual doctor (G.P.)/ dentist of the person whose condition/death caused this claim.

1. **Name of patient**

2. **Their date of birth:** (DD/MM/YYYY)

   / /

3. **Does he/she usually attend your practice?**

   ☐ No › Go to Question 4

   ☐ Yes › If so, how long?

4. **Do you have access to the patient's medical/clinical records?**

   ☐ Yes ☐ No

5. **Please provide a diagnosis and/or symptoms under investigation that has resulted in this claim:**

6. **Date of onset of symptoms:** (DD/MM/YYYY)

   / /

7. **Date you were first consulted:** (DD/MM/YYYY)

   / /

8. **Date of diagnosis:** (DD/MM/YYYY)

   / /

9. **In the case of pregnancy**
   Date pregnancy confirmed: (DD/MM/YYYY)

   / /

   Gestation on this day (weeks):

10. **Has your patient been referred to a specialist in relation to the condition in Question 5?**

    ☐ No › Go to Question 15

    ☐ Yes › If so, give details below

11. **Name of Specialist:**

12. **Contact details of specialist:**

13. Date referred: (DD/MM/YYYY)

☐ / ☐ / ☐

14. Date first attended specialist: (DD/MM/YYYY)

☐ / ☐ / ☐

15. Please provide details of medication relevant to the condition/symptoms listed in question 5:

medication ☐

medication ☐

medication ☐

medication ☐

medication ☐

16. Please give details of any chronic medical condition from which they suffer relevant to question 5:

☐

17. If relevant to this claim, did the patient consult you or another medical practitioner prior to commencing their trip? If yes, were they medically advised not to travel?

☐ No

☐ Yes › On what date?

From what date were they unfit to travel (DD/MM/YYYY)

☐ / ☐ / ☐

On which date would they be fit to travel again (DD/MM/YYYY)

☐ / ☐ / ☐

Doctor's Declaration

I declare that I have examined the patient named above and/or have referred to their medical records and confirm that the information given is a true and correct statement.

Name of Doctor/Dentist:

Signature:

Email:

Phone:

Fax:

Doctor's Stamp:

Date (DD/MM/YYYY)

☐ / ☐ / ☐

Expenses to be Claimed

Details of expenses	Date of expense	Supplier/Place of purchase	Currency	Amount	Refund/Reimbursement recieved	Amount paid	Invoice/Receipt attached
Doctor consult	DD/MM/YYYY	Lakeside Medical Centre	GBP	785.53	0.00	☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No
						☐ Yes ☐ No	☐ Yes ☐ No

4. Payment Details

If your claim is approved, we will deposit your refund in Australian Dollars directly into your nominated account. Unfortunately, we are unable to deposit into a credit card account.

Bank Details

Name of bank:

Branch:

Account holders name:

BSB Number - **Account number**

5. Declaration

Claims are handled by the dedicated claims team at nib Travel Services. nib Travel Services takes your privacy seriously. We use the information you provide to us to assess your claim and pursue any recovery. We may need to provide that information to other people, for example your insurers and any assessors, health professionals or others that we need to assist us in doing this. If you don't provide us with complete information, we will not be able to properly assess your claim. You can check the information we hold about you at any time.

For more information about how we use your personal information, please refer to the Privacy Notice in the Product Disclosure Statement.

I/We declare that all information provided is true and correct.

I/We authorise any person or organisation to provide nib Travel Services or its representative with any information that they may request in relation to this claim.

I/We agree that a photocopy of this authorisation is as effective and valid as the original.

Signature of claimant or Nominated Authority:

Name of claimant or Nominated Authority:

Date (DD/MM/YYYY)

/ /