



## DUAL Travel Insurance Claim Form

The issue of this form is not an admission of liability.

**ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED**

CLAIMANT DETAILS	
Name of Policyholder	
Policy Number	
Name of Traveller (Mr/Mrs/Miss/Ms)	
Occupation	Date of Birth
Address	
Telephone – Home	Business

TRAVEL INFORMATION	
Date of Departure:	Date of return / Expected Return:
Reason for Travel:	
Departure Country:	Departure City:
Destination Country:	Destination City:
CORPORATE TRAVEL AUTHORISATION	
Name:	Position:
Company Name:	
I hereby confirm that <b>(Claimant Name)</b> is an INSURED PERSON and was on an approved business JOURNEY on the Date of Loss.	
Signed:	Date:

### PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account. Please complete the following:

Bank: \_\_\_\_\_

SWIFT CODE (FOR NON AUSTRALIAN BANK): \_\_\_\_\_

Account Name(s): \_\_\_\_\_

BSB Number: \_\_\_\_\_

Account Number: \_\_\_\_\_

### GST Information (For Australian Claims Only)

(a) Are you registered for GST Purposes? **Yes No**

(b) What is your Australian Business Number (ABN)? : \_\_\_\_\_

**DUAL**

## DUAL Travel Insurance Claim Form

This form must be fully completed in the sections applicable to your claim and signed.

### LUGGAGE and PERSONAL EFFECTS and MONEY

Give full details of how loss damage or theft occurred: (Detail each event)


Date of occurrence ...../...../..... Time ..... am/pm  
 Date loss reported ...../...../..... Time ..... am/pm  
 Loss reported to – Name .....  
 Address.....  
 Were articles lost by Carrier? (e.g. Airline) Yes / No Name .....

Have you yet lodged a claim or complaint against any Carrier/Airline or other authority or against any individual responsible for the loss or damage to your property? If so, please give details and attach copies of correspondence.

Airline:	Claim No.

**NOTE:** The Warsaw Convention imposes a liability upon the Carrier and you should claim from them first.

Are any of the items covered by other Insurance? Yes / No  
 If yes – which Company? .....  
 Were all the missing articles your property? Yes / No If Yes – who is the owner? .....  
 Description and size of suitcase in which missing goods carried  
 .....  
 .....

...Continued Overleaf

**LUGGAGE and PERSONAL EFFECTS and MONEY BENEFIT (continued)**

Full details of articles claimed (include value of cases)	Name and address from whom goods were purchased	Date of purchase	Purchase price	Amount claimed	Remarks

**MONEY**

Date notified..... To whom .....

Which police were advised? State Police Station and attach copy report if available.

Description of the incident .....

Details of claim .....

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

1. Report or letter from Authority (e.g. Police, Airline) regarding the loss, where available.
2. Proof of purchase of lost goods (e.g. Receipts, Guarantee or Valuation Certificates, Card Vouchers, etc.)

\*Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the supporting documents please advise the reason.

.....  
 .....  
 .....

...Continued Overleaf



**Medical, Evacuation and Additional Expenses**

Type of Injury or sickness		Date of Accident or Commencement of sickness	
Injury – Give full details of Accident			
Date of First Medical Consultation		Name of Doctor or Hospital	
Details of other treatment by Doctors/Hospital			
Dates in hospital	Admitted	/ /	am/pm
	Discharged	/ /	am/pm

Have you ever suffered from the same or a similar complaint in the past? Yes / No

Yes, give details, dates, etc.


Are you a member of a Private Health Insurance Fund e.g. Medibank? Yes / No?

Name of Fund .....

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

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

1. Original Doctor's / Hospital accounts and receipts together with statements from Medicare and Private Health funds.
2. Original Doctor's Certificate.

\*Failure to provide these items may result in delays in processing your claim. If it is possible to provide any of the items please advise the reason:

.....  
 .....  
 .....

...Continued Overleaf

**DUAL**

**CANCELLATION and LOSS OF DEPOSITS**

What was the reason you could not commence your proposed journey or complete the return flight?


Was the cancellation as a result of Injury/Sickness to yourself? Yes / No

Was the cancellation as a result of Injury/Sickness to some other relative or person as defined in the Policy? Yes / No

***If Yes, please provide details***

Name	Address	Relationship	Age

Nature of complaint preventing travel .....

Date of first Medical Treatment .....

Has the Injured / Sick person had a similar condition in the past? Yes / No

Name and address of patient's normal Doctor .....

Date you advised Travel Agent to cancel bookings .....

Amount of Deposit paid and date paid \$ ..... Date .....

Balance of Full Fare and date paid \$ ..... Date .....

TOTAL PAID \$ .....

Refund received on cancellation \$ .....(excluding Insurance Premium)

Were any alternative arrangements offered or made? (Give details)

.....

.....

.....

Were any additional fares incurred as a result of cancellation (Give details)

.....

.....

.....

...Continued Overleaf

**DUAL**

**CANCELLATION and LOSS OF DEPOSITS (continued)**

*(Complete this section for additional expenses)*

Reason for incurring additional expenses or forfeiting travel or Accommodation expenses

.....  
.....

Details of expenses incurred

	A\$
	A\$
	A\$
	A\$

Were these expenses incurred as a result of Injury or Sickness as claimed on previous page? Yes/No

If these expenses were incurred as a result of Injury or Sickness to any other person, please give details of cause, name, address and age of person.

Cause

.....  
.....

Name & Details

.....  
.....  
.....

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

1. Original receipts and/or Tickets relating to additional expenses incurred
2. Proof of cause i.e. Original Doctor's/Hospital's Certificate relating to Injured or Sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport.

\*Failure to provide these items may result in delays in processing your claim. If it is impossible to provide any of the items please advise the reason:

.....  
.....  
.....  
.....

...Continued Overleaf

**DUAL**

**ACCIDENTAL DEATH CLAIM**

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

- 1. The Original Policy Document.
- 2. Original of the Death Certificate which will be returned to you.
- 3. Copy of Coroner's Depositions and Findings (if applicable)
- 4. Original Birth Certificate which will be returned to you.

**\*Failure to provide these items may result in delays in processing your claim.**

What was the cause of death?


When did the accident occur?

	Time	am/pm
--	------	-------

Was a coronial inquest held or is one to be held? If so give details

**Yes / No**


Name and Address of usual family doctor:


How long has the doctor been known to the patient?

--

**HIRE CAR EXCESS CLAIM**

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

- 1. The Hire Care Agreement.
- 2. Notice from the Hire Care Company in respect of the excess or deductible.
- 3. Documentation evidencing payment of excess or deductible.
- 4. A copy of the Hire Care Repair Invoice from the Hire Company.

**\*Failure to provide these items may result in delays in processing your claim.**

**Please provide a full description of the circumstances of the incident giving rise to the claim:**


**DUAL**

**Should your claim not fall under any of the above, please contact Proclaim for further details and to discuss coverage**

## **CLAIM LODGEMENT DETAILS**

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

*(Please keep a copy of all document sent to Proclaim)*

<b>Online Lodgement (preferred):</b> <ol style="list-style-type: none"><li>1. <a href="http://figapp.csc.com.au/proclaim/">http://figapp.csc.com.au/proclaim/</a></li><li>2. Login: dualah</li><li>3. Password: claims</li></ol> <p>(Please attach the completed claim form during the online lodgement and record the claim number)</p>	<b>Or by Postal Address:</b>  Proclaim Pty Ltd Locked Bag 32012 Collins Street East Victoria 8003
<b>Email Address:</b>  ahclaims@proclaim.com.au	<b>Fax No:</b>  1300 858 329
<b>Phone Number:</b>  Once the claim form has been completed, sent, and received by Proclaim, claim inquiries can be made to Proclaim on:  +61 (2) 92871322  Policy and coverage queries should first be directed to your Insurance Broker.	

### **PRIVACY STATEMENT**

DUAL Australia are committed to protecting your privacy. We use the personal information you provide to us in connection with your claim only for the purpose of assessing and managing the claim. We may need to provide that information to our underwriters and those we appoint to assist us with the claim. We will not trade, rent or sell your information. If you do not provide us with complete information, we cannot properly assess your claim. You can check the personal information we hold about you at any time. If you provide us with personal information about anyone else, we rely on you to have told them that you will provide their information to us, to whom we may provide it, the purposes for which we will use it and that they can access it. If the information is sensitive, we rely on you to have obtained their consent on these matters. For more information about our Privacy Policy, please refer to: [www.dualaustralia.com.au](http://www.dualaustralia.com.au)

### **DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS**

**I declare that** the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.

**I authorise** any hospital, physician or other person who has attended me to furnish the claims manager Proclaim Pty Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

**Your Signature:**

**Date:** / /

**Please Print Your Name**

**DUAL**