

You must register any claim within 30 days after completion of your travel. You need to supply to us original documents of the evidence you intend to rely upon in your claim, by registered post to ensure delivery.

Claimant Details			Claim Reference (if known)	
Title (Mr/Mrs etc)	Surname	Forename(s)	Date of Birth	
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	
Nationality		Occupation		
<input type="text"/>		<input type="text"/>		
Medicare Number	<input type="text"/>	Parent/Guardian's Medicare Number (If medical claim is for a minor)		
Home Address		☎ Home Phone		
<input type="text"/>		<input type="text"/>		
State		☎ Work Phone		
<input type="text"/>	Postcode	☎ Mobile		
<input type="text"/>	<input type="text"/>	☒ Email		
<input type="text"/>				

Policy Details				
Policy Number	<input type="text"/>	Date Issued	<input type="text"/> / <input type="text"/> / <input type="text"/>	Number in Party
Independent Travel Arrangements:		Yes <input type="checkbox"/>	No <input type="checkbox"/>	If no, provide the following *:
*Travel Agent & Branch		*Tour Operator		
<input type="text"/>		<input type="text"/>		
Date of Booking	Departure Date	Return Date	Total Days	
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	
Country	Resort/Town			
<input type="text"/>	<input type="text"/>			

It is against the law to submit a fraudulent insurance claim. If your claim is found to be fraudulent the claim will be declined and Insurers will pursue recovery by the use of legal action.

- I/We hereby declare that all information, answers, and documents given in connection with this claim are true and correct to the best of my/our knowledge and belief. I/We have not omitted any material information, which would affect the Underwriters judgment of the claim. I confirm that where a claim or claims are made on behalf of others, I have their full authority to act on their behalf, and I confirm that I understand that neither Mapfre Insurance Services Australia Pty Ltd nor the underwriters will accept responsibility if any payments are not distributed proportionately to the persons concerned.
- I/We understand that the information on this form will be passed to or used by Mapfre Insurance Services Australia Pty Ltd for my insurance, this includes underwriting, processing, handling claims and preventing fraud and could include passing details to agents or other Insurers. This includes access to my previous claims with other insurers.
- I/We subrogate all rights of recovery to Mapfre Insurance Services Australia Pty Ltd and also consent to them seeking reimbursement of any medical expenses paid by them.

**For medical related claims:**

- I authorise any doctor, hospital, general or travel insurer or other organisation or person having any records or information concerning my medical history or treatment to furnish such records or information as may be requested by Mapfre Insurance Services Australia Pty Ltd or their agents. I understand that in executing this authorisation, I waive the right for such information/records to be privileged. I am also aware that such information/records are relevant in the evaluation of my claim and that non-submission could prejudice my claim. A photocopy of this authorisation shall be considered as effective and valid as the original.

I have read and fully understand the declarations above (ALL persons claiming must sign)

Claimant's Name	Signature	Date of Birth	Date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>
Claimant's Name	Signature	Date of Birth	Date
<input type="text"/>	<input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/> / <input type="text"/> / <input type="text"/>

**Cancellation**

Reason for cancellation: *Please select one box only*

Illness  Injury  Death  Redundancy  Jury Service   
 Damage/Theft to Home/Business  Other

When did you become aware of the need to cancel your holiday:

Date  /  /  Time  AM  
 PM

When did you inform the airline, accommodation provider, travel agent or tour operator of the need to cancel your holiday:

Date  /  /  Time  AM  
 PM

If applicable, please give the name of the person who has caused the cancellation and their relationship:

Name  Relationship

**Details of holiday cost and cancellation charges:**

**Names and dates of birth of all those cancelling:**

Ticket costs	
Accommodation costs	
Pre-booked excursions	
Deduct refunds received or advised	
Total amount claimed	

Name	DOB

Please detail the reasons for cancellation below, giving details of any third party involved *(continue on a separate sheet at the end of the form if necessary)*

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**Documents You Need to Send Us - SEND ORIGINAL DOCUMENTS BUT KEEP COPIES FOR YOUR RECORDS**

1. The original trip cancellation invoice. If your booking was flight only you may not be able to obtain this document, if so, please obtain written confirmation from airline or travel agent.
2. Original booking invoice, showing date of booking, date of travel and a full breakdown of the trip costs. Please also supply all unused travel tickets, itineraries etc.
3. If cancellation is due to redundancy, we require a letter from your former employer which confirms you have been made redundant and are due to receive a payment under current Redundancy Payment Legislation, the position you held and your length of service.
4. If cancellation is on medical grounds, including death, the attached medical certificate must be completed by the usual medical practitioner of the individual whose condition has led to the submission of the claim.
5. If cancellation is due to a death, we also require a **certified copy** of the death certificate. In addition, if the deceased is an insured person under the policy, we require a **copy** of the Grant of Probate issued in respect of the deceased's estate.
6. If the claim is being submitted as a result of an injury please provide a full description of the incident leading to the injury; if a third party was involved please provide their details and those of their insurer, if available.
7. If claim is for trip abandonment, we require written confirmation from the airline of the delay/cancellation of the flight, the reason for the delay and the length of time the delay lasted.
8. If cancellation is for any other reason, please provide independent written evidence of the incident or circumstances which have resulted in the submission of the claim

**Other Insurances**

Do you (or anyone else claiming) have any other insurance which may cover this trip. eg Travel insurance with your bank/credit card account, tour operator/ travel agent or home contents insurance etc. NB (A contribution payment is normal practice where 2 policies cover the same loss)

Yes  No  If yes, please supply the following details:

Company name and address

Policy Number

Has a claim been submitted to any other company for this incident: Yes  No  If yes, please provide details:

**Previous Claims**

Have you made any previous claims on this type of insurance: Yes  No  If yes, please provide details:

Method of payment: Cash  Cheque  Credit/Debt Card  Reward points/Airmiles

If a Credit/ Debt card was used to pay all or some of the trip cost, please state:

Name of card supplier	Card type

**Medical Certificate**

This must be completed by the Registered General Practitioner (GP) of the person whose illness/injury/death has given rise to the claim. Any charge made for the completion of this certificate is the responsibility of the insured and is not refundable under the insurance policy. Please ensure the GP answers all relevant questions. Ticks, dashes, N/A etc will not be acceptable. This information will be treated as private and confidential. A certificate not containing the specific information requested will not normally suffice.

Full name of patient  Date of Birth  /  /

Are you the regular medical attendant/ from the same practice: Yes  No  If yes, for how long

If no, what is your involvement with this matter

State precise nature of the medical condition/illness/injury/cause of death, that gives rise to this claim

If injury, state how this was caused

If claim is result of pregnancy: Date pregnancy confirmed  /  /  LMP  /  /  EDC  /  /

Has patient suffered from the same or related condition in the past five years: Yes  No  If yes, for how long

State the exact date of onset of symptoms of conditions  /  /  Date first consulted  /  /

Date of any serious deterioration/exacerbation, if applicable  /  /

What ongoing medical condition(s), or medical complication directly attributable to the condition(s), were being investigated by a registered medical practitioner at:  
Date trip insurance was purchased  /  /  Date trip was booked  /  /

Is the illness/injury attributable to drugs, alcohol or HIV or HIV related illness, including AIDS: Yes  No

Give Details

Has the person named above received a terminal prognosis: Yes  No

If yes, what date was the terminal prognosis given to: The patient  /  /  The claimant  /  /   
*(if not the same person)*

Has the patient been referred to or seen by a hospital doctor or surgeon or needed inpatient treatment for this or any related condition within 12 months prior to the date the trip insurance was purchased? If so, please give full details including dates

If the patient was booked to travel did they consult you prior to booking or travelling regarding the advisability of undertaking the holiday or journey:  
Yes  No  If yes, on what date  /  /

If no, when would you have advised cancellation had you been aware of the planned trip

If the patient travelled, were they fit to travel the date of departure

Provide details of patient's state of health at the time the insurance was purchased and date of booking the trip

State exact reason for cancellation

Please advise the date when it first became apparent that the holiday should be cancelled  /  /

Please state the exact date you advised the need to cancel  /  /

Are you prepared to certify that, solely due to the condition described above, the claimants are compelled to cancel their holiday arrangements:  
Yes  No

To be completed by the usual Registered General Practitioner (GP): I have examined the patient and/or referred his/her medical records and I declare that the information given is correct and that no details relevant to the case have been omitted.

Name  Qualifications

Sign  Date  /  /



Bank Details

Should Mapfre Insurance Services need to reimburse you we require your bank details as follows:

Name of Account Holder

BSB

Account number

Separate sheet to continue any questions necessary

Lined area for additional information.