Accident & Health International
Underwriting Pty Ltd (AHI)
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ABN: 26 053 335 952
AFS Licence No: 238261

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In Australia: 1800 618 700
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Travel Insurance Claim Form for Miga Members

Important: please read before you complete this form

1. This form consists of several sections. Please provide answers to all of the information required and return it as soon as possible, so that we can assess your claim.
2. Please note that Sections 1, 2, 3, 4, 5 & 12 are compulsory.
3. Please attach any requested documents when you return this completed form.
4. This form can be completed electronically. If completing this form by hand, please print it.
5. The issue of this form is not an admission of liability by AHI or the insurer.

1. Your Details

All questions require completion

Policy Number
5612281

Expiry Date

Miga Membership Number

Your Position

Doctor | Doctor in Training | Medical Intern | Spouse | Dependent Child | Other:

Title

Given Name(s)

Gender
M | F | Other

Family Name

Date of Birth

Residential Address (cannot be a PO Box)

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

Are you able to claim through any other source? Yes | No

If Yes, please provide details

Have you made any travel insurance claims in the past 5 years? Yes | No

If Yes, please provide details

2. Payment Details

Compulsory

Please provide bank and account details for payment.

Account Holder's Name

BSB Number (6-Digits)

Account Number

Bank

(Alternatively supply a deposit slip noting the following information)

3. GST Declaration

Are you registered for GST Purposes? Yes | No

If Yes, what is your ABN?

Must be completed only in respect of:

- Each company owned item.
- Any other expenses where Australian GST is incurred by the company.

Have you ever claimed, or are you entitled to claim an Input Tax Credit (ITC) in respect to GST paid on the insurance policy under which this claim is being made? Yes | No

If Yes, what percentage of ITC did you claim or are you entitled to claim?

4. Travel Information

Compulsory

Departure Date

Return Date

Departure City

Destination City

Departure Country

Destination Country

Reason for Travel

Business/Work Holiday Combination Other

5. Details of Incident

Compulsory

Date of Incident Time AM/PM Incident City Incident Country

Please describe how the accident, damage, theft, loss or illness occurred and complete relevant sections of this Claims Form

6. Medical Expenses

If applicable

- This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.
- Medical receipts will be required to accompany this section.
- We reserve the right to call for details of medical history of the claimant, or the person whose accident, illness or death necessitates the curtailment of the journey.
- All medical and hospital accounts incurred within Australia must first be submitted to Medicare for refund, also to your private health fund if applicable.

Was the Emergency Assistance Company contacted? Yes No

If an illness, has the claimant suffered this complaint before? Yes No

If Yes, please provide details

Date of Expense	Medical and/or Hospital Expenses (use separate sheet if insufficient space)	Amount claimed (please state currency)

7. Lost, Stolen or Damaged Luggage & Personal Effects

If applicable

- In the event of loss or damage occurring whilst in the care of carriers (airlines, bus companies, etc) the carrier should have been notified and a Property Irregularity Report obtained and forwarded with this form.
- Full description of articles lost or damaged with details of the nature of damage, full particulars of purchase price and date and place of purchase are to be entered on the statement of claim below, together with proof of lost or damaged goods (e.g. receipts, valuation certificates, credit card statements).
- You should obtain an estimate for repairs where feasible or written confirmation from a competent repairer or dealer that the articles are damaged beyond economic repair.
- All optical expenses must first be submitted to your private health fund, if applicable.
- Lost/Stolen goods should be reported to the Police.

Was the incident reported to Police or any other authority? Yes No

If Yes, please provide report/incident number

If No, please provide explanation

Were articles lost by a carrier? Yes No

Note: The Warsaw Convention & The Montreal Conventions impose a liability upon the carrier and you should claim against them first.

Were all the missing articles your property? Yes No If No, who is the owner?

Have you 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? Yes No

If Yes, please provide details and attach correspondence

If No, please provide explanation

If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? Yes No

Name of private health fund

Membership number

Amount paid by private health fund

Currency

8. Delayed Baggage

If applicable

Date of Your Arrival

Time

AM/PM

Compensation Paid by Carrier

Currency

Date of Luggage Arrival

Time

AM/PM

Statement of Claim

Please provide a full description of the article(s) lost, damaged or delayed in the table below. Include a detailed description of damage where applicable e.g. water damage. Please attach relevant documentation to support your claim, e.g. receipts, photographs, and manuals. If there is insufficient room please attach in a separate sheet.

List and describe the items lost, damaged or delayed.	Original cost price	Date and place of purchase	Has item been replaced	ITC%	Amount claimed	CUR
e.g Dell Latitude x150 - Cracked Monitor – photo #1	*$2,600 AUD*	*26/06/2018 - Dell website*	*No*	*65%*	*$2,600*	*US*

9. Additional or Forfeited Expenses

If applicable

- This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the insured travel.
- Only original accounts or receipts for accommodation and transport costs will be accepted.
- For additional expenses, a MEDICAL CERTIFICATE, or the Medical Certificate on Page 6 of this form, from the doctor who treated you must be provided to support change of plans due to accident, illness or death.

If you are claiming for additional expenses, what were your original plans for accommodation/transport and how were they changed?
Please ensure copies of original and amended itineraries are provided.

Date of Expense	Additional transport/Accommodation expenses (please supply full details)	Amount claimed (please state currency)

Date of Expense	Forfeited expenses (please supply full details)	Amount claimed (please state currency)

10. Hire Car Expenses

If applicable

Please ensure a copy of your Hire Vehicle Agreement, Damage Report and repair invoice(s) are attached.

Car Other

Name of vehicle hire company

Title

Driver's full details

Rental vehicle excess $ Currency

Actual repair costs $ Currency

Amount you are claiming $ Currency

11. Cancellation/Loss of Deposits

If applicable

- If you are claiming because you cancelled your trip PRIOR to departure, as a result of injury, illness or death, you MUST have the Medical Certificate on Page 6 completed by the regular doctor of the person whose state of health has resulted in the claim.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the cancellation of the journey.
- A supporting document from the travel provider showing cancellation charges must be submitted with this form.

Date travel arrangements booked: Date of cancellation:

Reason for cancellation:

If cancellation is due to accident, illness or death state the name of the person whose accident, illness or death necessitates the cancellation of the travel. IN THE EVENT OF DEATH, PLEASE ALSO ATTACH THEIR DEATH CERTIFICATE.

Title Given Name(s)

Family Name

Relationship of person to claimant

Amount paid	Currency	Amount refunded	Currency	Amount claiming	Currency
$		$		$	

If no refund amount is noted please state why (you must obtain all refunds possible).

12. Declaration

Compulsory

General Insurance Code of Practice
AHI proudly supports the General Insurance Code of Practice (the 'Code'). The purpose of the Code is to raise the standards of practice and service in the general insurance industry. For further information on the Code, please visit www.codeofpractice.com.au.

Complaints
If there are any concerns or complaints about AHI's products or service, AHI's staff are always available to listen and help where they can. We will attempt to resolve your complaint immediately, but if we cannot, we will acknowledge your complaint and advise you of the procedures we will follow in handling and investigating your complaint.

We will keep you up to date regarding our progress and will endeavour to respond to your complaint within 30 calendar days. Our response will be in writing and will advise you of the outcome of our investigations and our proposed resolution of your complaint. If we cannot resolve your complaint within 30 calendar days, we will write to you and provide you with details of the Australian Financial Complaints Authority so that you may consider taking your complaint to them.

By signing this Claims Form below, you agree to the following:

Declaration
The person completing this form declares that their answers are accurate and complete, and acknowledges that the insurance claim may be declined if that is not the case.

Authority to release medical and/or dental records
The Claimant completing this Claim Form authorises any hospital, physician or dentist, who has treated them to provide Accident & Health International Underwriting Pty Ltd (AHI) with copies of their medical and/or dental records, or of their past medical and/or dental history, as specifically requested by AHI.

This Authority extends to the circumstance in which the Claimant is the legal parent, or legally appointment guardian, of a child (who is to be referred to as the Patient in Section 13 of this Form) who is deemed by the holder of the records as not having the capacity to personally consent to this request by AHI for access, in circumstances when this request relates to the medical and/or dental records of that child.

Privacy Statement
The person submitting this Claim Form agrees that the personal information it contains will be collected by Accident & Health International Underwriting Pty Ltd (AHI) and managed in accordance with its privacy policy which can be read online at ahiinsurance.com.au/privacy or by calling AHI on (02) 9251 8700 to ask for a copy.

AHI handles all personal information in accordance with the Privacy Act 1988. It collects personal information directly, through its agents and other companies within the Tokio Marine global corporate group. AHI uses the personal information it collects to conduct its business, including assessing insurance claims, which it cannot do if it is not able to receive this information.

AHI may send personal information it collects overseas, including Japan, USA, Canada, Bermuda, New Zealand, Thailand, Hong Kong, Europe (including the United Kingdom), Singapore and India. Contact AHI for more information about how it handles personal information or if you have a privacy complaint.

Signature of Claimant

Date

Signature of the Insured Person (if not the Claimaint)

Date

AHI

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Medical Certificate

The claimant must obtain at own expense from the patient's usual doctor or dentist in all cases.
Important: the medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries.

13. Patient's Details

Compulsory

Title | Given Name(s) | Date of Birth

Family Name

1. Are you his/her/their usual medical attendant? Yes No

2. If Yes, for how long? Days Months Years

3. Please give precise details of the nature of the illness or injury

4. Start date of onset of illness

5. State date on which you were first consulted in relation to the condition described above and, in your opinion, how long the condition has been present prior to consultation.

First Consultation Date | Condition has been present prior to consultation for

6. Are you prepared to certify that solely, due to the condition described in question 3, the claimant was compelled to cancel the travel arrangements? Yes No

7. What treatment, if any, has your patient previously received for this or any other related condition, and when was treatment received?

8. Is he/she/they suffering from any chronic disease or illness or from any physical defect or infirmity?

9. If the claim is as a result of a death, in your opinion, was it sudden and unexpected? Please give reasons for your answer

Print Name | Qualification | Signature

Address | Phone | Email | Date