

Claim Form

Please complete and sign and return to Chartis, Box 1745, Auckland 1072

Policyholder Details

Full Policy No

Telephone – Day After hours

Name of Traveller/s (Mr/Mrs/Miss/Ms)

Address

Email Occupation

Date of Birth

Credit Card (circle) Gold / Platinum / Titanium Card Number

Issued by which bank?

On what date did you pay for this travel on your card?

Period of Journey: Total Number of Days: From to

Purpose of Your travel (Please circle) Leisure Only / Business Only / Leisure and Business please give details

Cancellation / Additional Expenses

Cancellation of journey:

Please give reason

Date you advised Travel Agent to cancel bookings (if applicable) Date of Incident causing Loss

If cancellation costs or additional expenses were incurred due to Injury/Sickness:

Name of person Relationship to You

Address Age

Describe the Injury/Illness

Date of First Treatment Has the patient EVER had a similar condition before? YES / NO

Patients Usual Doctor Name; Address & phone number

Amount of Deposit paid \$ Date Paid

Balance of Full Fare paid \$ Date Paid

TOTAL PAID \$

LESS Refund on cancellation \$ Date Received

Were any additional fares incurred as a result of cancellation YES / NO Give details

Were any alternative arrangements sought by You or alternative offers made? YES / NO Give details

Reason for incurring additional expenses or forfeiting travel or Accommodation expenses

Date of First Medical Consultation / /

Name & Address of Doctor or Hospital

Name & Address of any other Doctor/s or Hospital/s who treated you

Hospital:

Admitted / / AM / PM

Discharged / / AM / PM

Have you EVER suffered from the same or a similar complaint in the past? YES / NO

If Yes, give details, dates, duration etc.

NB. If you are a member of a Private Health fund you must claim from that fund before submitting this claim.

Are you a member of a Private Health Insurance fund e.g. Southern Cross YES / NO

Name of Insurer

Details of expenses incurred (attach list if required) Description of Item	Cost NZ\$
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
TOTAL	NZ\$

THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Original Doctors/Hospital accounts and receipts together with statements from your Private Health Insurer/ACC details.
2. Original Doctors Certificate.

Personal Money

Date of Loss / /

Place of Loss

Date Notified / /

Which Police Station was advised?

Amount Claimed \$

(Attach copy report if available)

Description of the incident

Personal Liability

Date of Incident / /

Bodily Injury

Name and Address of Injured Party

Details of Injury

Is the Injury or Damage related to a travelling companion? YES / NO

Is this person related to You? YES / NO Give Details

Damage to Third Party Property

Name and Address of Party claiming against You

Describe Property Damage

Do you consider you were at fault? YES / NO (If yes, why)

Letters or Demands (including Rental Agreement and Damage Reports where applicable) of a claim made on you Must Be Included With This Claim

Payment

Option 1: Direct credit to NZ bank account. Please complete bank details and account number below

OFFICE USE
Bank a/c checked

Option 2 Overseas Bank Transfer

Bank Branch Country

Account details

Chartis no longer issues cheques. To confirm transfer of funds, an auto email will be sent to your broker or direct

Email: Broker/Payee

Payee Signature

Payee Name

Declaration; Authority & Privacy Consent

Insured Traveller Must Sign Below

I/we (print name/s)

declare that the above answers and those contained in any attachments are true and note that the Insurer may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to provide Chartis Insurance New Zealand Limited ('Chartis') with assistance in dealing with this matter and understand that failure to co-operate with Chartis and to provide all information relevant to the circumstance may result in my/our claim being denied.

AUTHORITY:

I/we authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish Chartis or its representatives with:

- I. copies of hospital and medical reports/notes;
- II. copies of employment records and income tax returns; to the extent that they are relevant to the claim and
- III. information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

I/we agree that a photocopy of this authorisation shall be considered as effective and valid as the original and authorise its use as such.

PRIVACY:

I/we consent to Chartis in accordance with the Privacy Act 1993:

1. collecting holding and using personal information including information by audio, photographic or video surveillance, provided for purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
2. disclosing personal information submitted to another Chartis company, its staff members, the insured, other insurers and re-insurers, law enforcement agencies, investigators, lawyers, assessors, advisors and the agent of any of these, insurance broker, insurance agent or intermediary, employer for the purpose of administering my claim or providing a report.

Information is provided voluntarily however if we do not collect this information we may not be able to assess a claim. Insured persons have rights of access and correction to their personal information under the Privacy Act. Further information about this or making a privacy complaint can be obtained by emailing : Privacy.officerNZ@chartisinsurance.com

NOTE: Chartis will only seek information which in its opinion it believes to be relevant to investigation of the claim I/we consent to Chartis' assistance provider, Travel Guard, recording of all calls to the assistance service provided under the Travel Insurance for quality assurance, training and verification purposes.

Signature /s of Insured person/s: Date

If you are signing on behalf of the Insured person please state your authority to do so and relationship. Please complete:

Name Phone

Position of Authority to sign – Nature of Relationship

- **You will need to attach substantiating documents as specified in this claim form.**
- **Failure to provide substantiating items may result in delays in processing your claim – if it is impossible to provide any of the items required please advise the reason.**
- **The issue of this form is not an admission of liability and is without prejudice**

Chartis
PO Box 1745, Shortland Street
Auckland 1140
New Zealand
+64 9 355 3100 Telephone
+64 9 355 3135 Facsimile
www.chartisinsurance.co.nz