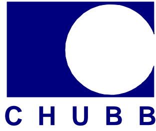


CHUBB INSURANCE COMPANY OF AUSTRALIA LIMITED

**A.B.N. 69 003 710 647**
**AFS Licence No. 239778**
**Sydney: Level 36, Tower Building Australia Square, 264-278 George Street, Sydney, NSW, 2000 Australia**
Telephone : 61-2-9273 0100 λ Facsimile: 61-2-9273 0101
**Melbourne: Level 14, 330 Collins Street, Melbourne Victoria 3000 Australia**
Telephone : 61-3-9242 5111 λ Facsimile: 61-3-9642 0909
**Perth: Level 22, Exchange Plaza, 2 The Esplanade, Perth WA, 6000, Australia**
Telephone : 61-8-6211 7777 λ Facsimile: 61-8-9325 7730


# Corporate Travel Claim Form

Employer.......................................................................Policy Number..................................................

Name (Mr/Mrs/Miss/Ms):........................................................................................................................................

Address: ..............................................................................................................................................................

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

Telephone: (Home) .................................. (Work) .............................. E-Mail ..........................................................

Date of birth: / /19

Reason for Travel: ..........................................................................................................................................

Date of Departure: / / Date of Return: / /

Destination: .....................................................Method of Travel: ........................................................................

<u>Luggage, Personal Effects, Travel Documents, Money & Credit Cards</u>

Date of Event: / / Where did the Event occur?..................................................................................

Brief Description:(including cause of loss or damage)

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

Is any Third Party to blame for loss or damage? ☐ No ☐ Yes If so, who?................................................................

Have the Police been notified? ☐ No ☐ Yes Date Reported: / /

Have you taken any other action to recover or reduce your loss? ☐ No ☐ Yes

If Yes, please provide details ..................................................................................................................................

Name of the owner of property lost/stolen/damaged: ..........................................................................................

Are any of the Items covered by other Insurance? (eg. Credit cards, home & contents insurance etc.) ☐ No ☐ Yes

If yes, please provide details: ..................................................................................................................................

<u>Detailed Statement of Claim</u>
*(Please attach – Proof of ownership (eg. original receipts, manuals, warranties), replacement quotations or receipts, copy of Police Report)*

| Full Description of property lost/stolen/damaged: | Date of Purchase | Replacement Cost |
|---|---|---|
| ..................................................................................... | .............................................. | ........................................ |
| ..................................................................................... | .............................................. | ........................................ |

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

If insufficient space, please provide details on a separate piece of paper

## Cancellation & Additional Expenses

*(Please attach – Receipts/tickets relating to additional expenses incurred, Letter from Travel Agent/carrier verifying reason for additional expenses and any refunds, Letter from Physician explaining why Insured person is unfit for travel)*

Date: / /

Details of Additional Expense:

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

Amount: (A$ or other currency): $....................................

## Personal Injury and Medical Expenses

*(In the event of injury or sickness please contact Customer Care on* ***61 2 9929 2216*** *(reverse charge anywhere in the world) (please attach Medical Certificates & reports, original Medical receipts)*

Date of Injury or Sickness / / Type of Injury or Sickness: ...............................................................................

Did you seek Medical consultation? ☐ No ☐ Yes

Name and Address of attending Physician:

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

## Medical Expenses

Describe Procedures, Medical Services, Supplies Furnished:

| Date | Medical Services | Amount |
| --- | --- | --- |
| ........................................ | .............................................................................................................. ... | .......................................... |
| ........................................ | .............................................................................................................. ... | .......................................... |
| ........................................ | .............................................................................................................. ... | .......................................... |
| ........................................ | .............................................................................................................. ... | .......................................... |
| | Total: | .................................... |

Amount: (A$ or other currency): $...........................................

## Other Comments / Claim

(Please provide details)

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

If you would like your claim payment made direct to an account please advise:
Account Name:_____________________________________Account No.________________
Bank address: _____________________________________ BSB No. ______________________ Bank.________________
If the account is overseas you will also need to specify the account address:

## Collection statement

**Your access**
You have a right to access the information collected on this form.
**Our use of your information**
We will use the information you have given us to:
1. underwrite your policy;
2. ascertain the value of your policy and things insured by it;
3. process your policy;
4. respond to claims that you make; and
5. assess future proposals for insurance.

**Disclosure of your information**
We may disclose the information you have given us to the following organisations (some of which may be outside Australia):
1. re-insurers, to underwrite your policy;
2. external valuers, to ascertain the value of your policy and things insured by it;
3. organisations that provide services to us in relation to the provision of insurance, to assist us in processing your policy or your claims (for example, investigators, assessors, information technology contractors, and lawyers); and
4. organisations that provide services to us in relation to the management of insurance risks.

**If you do not provide us with your information**
We need this information to insure you and, or, your property against any insurable losses and to respond to any claims you may make. If you do not give us this information we cannot insure you against such losses.
**Our privacy policy**
Please contact us if you would like information about our privacy policy.

## Statements of consent

I give the information contained in this form to the Chubb Insurance Company of Australia Limited (‘Chubb’) for any of the above purposes. I understand that this information may be disclosed to, and held by, any organisations set out above for the purposes outlined. I consent to Chubb using the information contained in this form for these purposes, and disclosing it to the organisations set out above for these purposes.

### Declaration

I/We do hereby declare that the foregoing answers are true and correct. I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim could be forfeighted.

Employees Signature: ....................................................................................

Date: / /

**AUTHORITY TO GIVE INFORMATION** (To be signed by the Claimant)

I/We hereby authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the underwriter such information as it may require regarding any illness and/or injury to me or my physical or mental condition or prognosis, or my employment, to assist in the proof and settlement of my claim. A photocopy or xerography copy of this authority can be acted upon as if it were original.

Signed ____________________________________________ Date ____/____/_____

Note: **The issue of acceptance of this form is not to be construed as an admission of liability on the part of Chubb Insurance Australia.**