



Send Claim to:
Corporate Services Network (CSN)
Level 2, 280 George Street
SYDNEY NSW 2000
Telephone: +61 2 8256 1770
Fax: +61 2 8256 1775
Email: claims@csnet.com.au

BUSINESS TRAVEL INSURANCE CLAIM FORM

1. This form must be fully completed in the sections applicable to your claim and signed.
2. The Privacy Consent section must also be signed for all claims.
3. For baggage/business property, electronic equipment and money/travel documents claims – attach invoices, valuations or receipts to support the value of the items being claimed and, most importantly, written confirmation from the Police, Local Government or carrier supporting your notification of the loss (if applicable).
4. For medical claims – enclose all the relevant documents to support your claim. Medical reports may be necessary, therefore the Medical Authority on this form must also be signed and completed by you.
5. For damage or loss by the carrier, cancellation and curtailment, loss of deposits or additional expenses claims – obtain written advice from the carrier involved as to the amount of the refund obtainable from them as a result of the damage or loss of articles, cancellation or curtailment of the journey, loss of deposits or additional expenses.

The issue of this form is not an admission of liability by ACE Insurance Limited (the insurer) or a waiver of its rights and is without prejudice.

ALL QUESTIONS IN THIS SECTION MUST BE ANSWERED

Name of Insured (Policyholder Company/Business/Partnership etc): _____
Name of Insured Person (Claimant) (Mr/Mrs/Miss/Ms): _____
Occupation: _____ Date of Birth: _____
Address: _____ Email Address: _____
Telephone: Home: _____ Business: _____ Mobile: _____
Policy Number: _____ Certificate of Access to Cover Number (if applicable): _____

ELECTRONIC FUNDS TRANSFER DETAILS

Following approval of your claim, your claim benefits will be transferred directly into your bank account. Please provide the following details:

Bank Draft in the following currency _____, or;

Direct to Bank Account Details Below:

Bank/Financial Institution: _____ Address: _____
Account Name: _____
BSB Number: _____ Account Number: _____
SWIFT: _____

PRIVACY CONSENT, INFORMATION AUTHORITY AND WARRANTY

Protection of my privacy Acknowledgements and consents

By signing this consent, I understand that Corporate Services Network (CSN) collects my information on behalf of ACE Insurance Limited ABN 23 001 642 020 (ACE) as ACE's agent. I agree that ACE and third parties such as my insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by ACE, my employers (past and present), my accountant, any business which provides information about the commercial activities of persons and if I am or have been bankrupt, the trustee of my estate ('the Parties') may exchange with each other any information about me, excluding health or other sensitive information, including:

- any information provided by me in relation to my claim;
- any other personal information I provide to any of them or which they otherwise lawfully obtain about me;
- any information relating to this insurance or any other insurance held by me or on my life, including terms and conditions and claims history;
- details of my employment, including position, period of employment, remuneration, hours worked and duties performed; and
- any information relating to my income and solvency.

I agree that any information referred to above can be used by the Parties and any Service Provider (as identified below) for assessing the claim or my entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

I agree that ACE may exchange my personal and/or sensitive information, for the purposes of assessing the claim or my entitlement to benefits with the following Service Providers:

- any investigator appointed by ACE to investigate the claim;
- the Health Record Holders;
- the Health Insurance Commission;
- other insurers;
- reinsurers;
- any private or government organisation which investigates fraud including the police; and
- any witness identified by me.

If I have identified any person as a witness, I agree to ensure that each person is made aware that:

- I have identified him/her as a witness in relation to the claim;
- ACE holds a record of their personal information for this purpose; and
- He/she may contact ACE or request access to his/her information, by calling 1800 815 675.

If ACE engages anyone (a 'Service Provider') to do something on its behalf (for example technology providers) then I agree to them exchanging any information referred to above, with each other.

I understand ACE might give any information referred to above to entities other than the Parties, the Service Providers, the Health Record Holders and the other persons/organisations referred to above where it is required or allowed by law or where I have otherwise consented.

I understand that I can access** most personal information that members of ACE hold about me (sometimes there will be a reason why that is not possible, in which case I will be told why).

I understand that if I fail to provide any information requested in this form, or do not agree to any of the possible exchanges or uses detailed above, ACE may be unable to assess the claim.

** To find out what sort of personal information ACE has about you, or to make a request for access, please telephone 1800 815 675

I consent to the collection, use and disclosure of personal information by ACE and their Service Providers in order to assess the claim. I understand that ACE complies with its obligations under the Privacy Act 1988 (Cth) and the principles laid out in its privacy policy, which is readily available on request.

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Date: _____

Signature: _____

PERSONAL ACCIDENT & SICKNESS (INCLUDING DENTAL) AND MEDICAL & ADDITIONAL EXPENSES CLAIM

Type of Injury or Sickness		Date of Accident or Commencement of Sickness
If 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
List the Country and the currency of the Country in which you incurred the medical costs	Country:	Currency: Total Amount
	Country:	Currency: Total Amount
Have you ever suffered from the same or similar complaint in the past?	Yes / No	
If Yes, give details, dates, names and addresses of treating physicians		
Name and address of usual treating doctor.		
How long has the doctor been known to the patient?		
Are you a member of a private health insurance fund (eg. Medibank).	Yes / No	Name of fund:

PLEASE NOTE: All medical accounts must first be lodged with your private health fund, if applicable.

THE FOLLOWING ITEMS MUST BE INCLUDED WITH A CLAIM UNDER THE ABOVE SECTION:

1. Original Doctor/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 impossible to provide any of the supporting documents please advise the reason.

CANCELLATION AND CURTAILMENT EXPENSES, LOSS OF DEPOSITS CLAIM

What was the reason you could not commence or complete your proposed journey?	
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 : Name	Address
Relationship	Age
Nature of complaint preventing travel	
Date you advised Travel Agent to cancel bookings	/ /
Amount of Deposit paid and date paid	\$ Date
Balance of Full Fare and date paid	\$ Date
Value of Fortified Portion of Journey (if applicable)	\$
Refund received on cancellation	\$
Full amount being claimed	\$
Were any alternative arrangements offered?	
If so, give details	
Did you accept any of the alternative arrangements?	Yes/No
What additional fares did you incur as a result of the arrangement?	

- You will also need to fill out the Missed Transport, Cancellation & Curtailment Claim section on the following page.

THE FOLLOWING ITEMS MUST BE INCLUDED WITH A CLAIM UNDER THE ABOVE SECTION:

1. Original receipts and/or Tickets relating to additional expenses incurred.
2. Proof of cause ie. Original Doctor/Hospital 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 supporting documents please advise the reason.

PERSONAL LIABILITY CLAIM

Bodily Injury – Provide relevant details – Name Address of injured Party and details of Injury	
Damage to Property – List all Property Damage together with Name and Address or Party claiming damage against you	
Is the Injury or Damage related to a travelling companion?	Yes/No
Do you consider you were at fault?	Yes/No
If so, why	

THE FOLLOWING ITEMS MUST BE INCLUDED WITH A CLAIM UNDER THE ABOVE SECTION:

1. Letter or document of a claim made on you.

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

MISSED TRANSPORT, CANCELLATION & CURTAILMENT CLAIM

(For additional travel and accommodation incurred during the journey)

Reason for incurring additional travel or accommodation expenses			
List the Country and the Currency of the Country in which you incurred the costs	Country:	Currency:	
List specifically the additional TRAVEL expenses	Details	Amount	
		A\$	
		A\$	
		A\$	
	TOTAL	A\$	
List Specifically the additional ACCOMMODATION expenses	Details	Amount	
		A\$	
		A\$	
		A\$	
	TOTAL	A\$	
Were these expenses incurred as a result of Injury or Sickness as claimed in Part 1? 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, age of person and relationship to you	Name		Age
	Address		Relationship
Cause			

THE FOLLOWING ITEMS MUST BE INCLUDED WITH A CLAIM UNDER THE ABOVE SECTION:

1. Receipts and/or tickets relating to additional expenses incurred.
2. Doctor/Hospital certificate specifying exact nature of condition suffered by injured/sick person.
3. Letter from the travel agent or carrier verifying reason for additional expenses and/or any refund applicable.

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

RENTAL VEHICLE EXCESS WAIVER CLAIM

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

THE FOLLOWING ITEMS MUST BE INCLUDED WITH A CLAIM UNDER THE ABOVE SECTION:

1. The Rental Agreement.
2. Notice from the Rental Company in respect of the excess or deductible.
3. Documentation evidencing payment of excess or deductible.

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

PERSONAL ACCIDENT & SICKNESS - ACCIDENTAL DEATH CLAIM

What was the cause of the Accidental Death?	

When did the accident occur?		Time	am/pm
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Was a coronial inquest held or is one to be held?	Yes/No
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If yes, give details

Place where inquest held

THE FOLLOWING ITEMS MUST BE INCLUDED WITH A CLAIM UNDER THE ABOVE SECTION:

1. The original policy document.
2. Original of the death certificate which will be returned to you.
3. Copy of the 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. It is impossible to provide any of the supporting documents please advise the reason.

MEDICAL AUTHORITY AND DECLARATION

I declare that:

- I will use my best endeavours and render all reasonable assistance and co-operation to ACE and its representatives in the assessment of my claim;
- the information supplied by me is true and correct and that I have not withheld any information likely to affect the acceptance of the claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I hereby appoint ACE and its agents to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I hereby authorise any person, hospital, physician, corporation, institution, private or government organisation, whether named by me or not, to provide such information as ACE, or its representatives (eg CSN), in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, hospital, surgical or other information concerning myself, including but not limited to reports/notes of my medical history (any sickness or disease or injury, consultation, prescription or treatment), any treatment received by me and any medication taken or prescribed for me (at any time);
- my Health Insurance claims history, including Medicare;
- any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that ACE relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Signature of Insured Person (Claimant): _____ Date: _____

Signature of Witness: _____ Date: _____