

TRAVEL CLAIM FORM

THIS FORM SHOULD BE COMPLETED AND RETURNED TO:

ReddiFund - Suite 2 / Level 1 / 44 Parliament Place, West Perth WA 6005

Email: info@reddifund.com.au

Phone: **08 9481 0259**

TRAVELLERS DETAILS

Full Name:			
Residential Address:			
State:		Postcode:	
Telephone Number:		Mobile Number:	
Occupation:			
Email:			
Date of Birth:			

TRAVEL AGENT

Name of Agent:			
Telephone Number:		Date of Booking:	
Date of Departure:		Date of Return:	
Have you made previous claims for travel insurance?	<input type="checkbox"/> YES	<input type="checkbox"/> NO	
If YES, please give details:			
Name of Insurer	Date of Claim		

A. CANCELLATION CLAIMS

Please attach the following documents which are required in support of your claim;

- Travel Agent's letter confirming details of tour costings and cancellation charges
- Doctor's Certificate (see Medical Certificate)
- Transport Provider's Reports

Reasons for Cancellation:

Date of Cancellation:

Where cancellation was due to accident, illness or death, please state the name of the person whose accident, illness or death necessitated the cancellation.

Name:

Relationship to Insured:

Amount claimed for recoverable prepaid travel costs:

\$

B. LUGGAGE AND PERSONAL EFFECTS

The following documents are required in support of your claim – Please tick when attached -

Police or responsible authority's report

Original purchase receipts/proof of ownership

Quotation for repair of damage

Transport provider's reports

Date of loss:

Time:

AM

PM

Location:

Country:

Please state exactly what happened:

What action did you take to recover the lost article?

Which responsible authority e.g. Police was notified?

Date Notified:

Time

AM

PM

Location:

Are your home contents insured?

YES

NO

Name of Insurer:

Policy No:

Are you a member of a Private Health Fund?			YES <input type="checkbox"/>	NO <input type="checkbox"/>
Name of Fund:		Policy No:		
Please Note: If you are entitled to recover losses from any other insurance policy, or other source, please do so and give details of amounts recovered:				
Full description of articles(s) and details of loss or damage where applicable				
Place of Purchase	Date of Purchase	Original Purchase Price	Amount Claimed	
C. MEDICAL EMERGENCY AND ADDITIONAL EXPENSES CLAIM				
The following documents are required in support of your claim – Please tick when attached -				
Original medical/hospital accounts			<input type="checkbox"/>	
Accounts in support of accommodation expenses			<input type="checkbox"/>	
Medical certificates supporting need for altered travel plans			<input type="checkbox"/>	
Copy of Travel itinerary			<input type="checkbox"/>	
Date of accident/illness circumstances:				
Country:		Time:	AM <input type="checkbox"/>	PM <input type="checkbox"/>
Particulars of Claim:				
If your claim arises from injury or illness, please specify the nature of such injury or illness:				
Name of person whose injury or illness caused additional expenditure:				
Their relationship to you:				
Has the injury or illness occurred before?			YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, please supply the following details:				
Usual Doctor's Name:				
Telephone No:		Date of last visit:		

If additional expenses have been incurred as a result of an accident, illness or death of a person in Australia, please state their relationship to you:

1.Expenditure for which reimbursement is claimed	Service	Amount Claimed
Provider (e.g. Dr J Smith, Bali Hospital etc.)		
2.Additional Expenses		
3.Cancellation/loss deposits (Please attach documents from your travel agent showing cancellation charges)		

MEDICAL AUTHORITY

With regards to medical, cancellation and/or additional expenses :

I hereby authorise any hospital, physician or other person who has attended or examined me to furnish the Trust Manager or their representative any and all information in respect of treatment given for:

A Photostat copy of this authorisation shall be considered as effective and valid as the original.

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Name of usual Doctor:					
Address of usual Doctor:					
State:		Postcode:		Phone Number	

PHYSICIANS STATEMENT ATTACHED – MUST BE COMPLETED BY DOCTOR

AUTHORITY & DECLARATION

I/we hereby authorise any hospital, physician or other person who has attended me to furnish Echelon Claims Services, or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records.

I/we agree that a Photostat copy or facsimile copy of this authorisation shall be considered as effective and valid as the original and I hereby undertake and agree to notify the Trust's Claims Manager immediately if any of the lost or stolen property mentioned in this claim is subsequently recovered, and at the option of the Trust's Claims Manager, to return the property or to refund the amount of money received, by way of compensation in respect thereof.

I/we the undersigned hereby acknowledge and agree to the information contained herein (including our personal information) being shared with the other members of our Discretionary Trust (Trust) as part of the Trust's Risk Management processes and reporting criteria with Reddifund, as it may be required to assist in the management of this claim and the administration of the Trust.

BANKING DETAILS

Account Name:	
BSB:	
Account Number:	
Email Address:	
Please Print Name:	
Signature:	
Dated:	

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM.

ATTENDING PHYSICIANS STATEMENT (To be completed by your attending physician)

THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Patient's Name: Patient's Address: When did the patient suffer the injury? What were the circumstances surrounding the injury?
When did the patient first receive medical treatment?
Please give a complete diagnosis of this condition.

Please give results of any objective findings – (Detail tests done and findings)

	Test	Findings
1.	X-Rays	<input type="text"/>
2.	Other Tests	<input type="text"/>
		<input type="text"/>

Was the patient confined to hospital? YES NO If YES, please advise the name and address of hospital: Period of confinement: From To What other treatment has the patient undergone? What other treatment is required? **HISTORY**Was there a previous history or a similar condition? YES NO If YES, please state condition and advise when previous treatment was given -
How long have you known the patient? Are you the regular General Practitioner? YES NO If NOT, please advise who is

DEGREE OF DISABILITY			
When was the patient obligated to cease work?			
If patient is still unfit for work, when approximately will the patient be able to resume?			
If patient has recovered, when was patient able to resume work?			
Are there any underlying conditions affecting recovery from the current condition?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, please advise nature of underlying conditions and how they affect disability and recovery:			
Please advise names and addresses of other treating physicians?			
If you have terminated treatment, please advise the date?			
What is the current prognosis?			
Are there any further remarks which may assist in assessing this condition?			
Is there any permanent disability at present?		YES <input type="checkbox"/>	NO <input type="checkbox"/>
If YES, please explain, giving estimated percentage of loss of function?			
Name: (Please Print)			
Signed:			
Dated:			
Address:			
State:		Postcode:	
Telephone Number:			



ECHELON AUSTRALIA PTY LTD

ABN 96 085 720 056

COLLECTION STATEMENT UNDER PRIVACY ACT 1988 (Cth)

In accordance with the Privacy Act 1988 (Cth) and any subsequent amendments (the Privacy Act), we Echelon Australia Pty Ltd (Echelon), including Echelon Claims Services, draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for any of the following purposes (depending on your requirements):
 - approaching the (re)insurance market;
 - placing insurance or providing alternative coverage;
 - assessing and advising you on your insurance or coverage needs;
 - providing claims handling or risk management services;
 - providing you with information about other JLT products or services; and
 - administering payments to you.
- The information we collect may be disclosed to third parties including but not limited to: (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and other Echelon related group companies, such as JLT Risk Solutions Pty Ltd and JLT Group Services Pty Ltd. Echelon is a business of Marsh and McLennan Companies (MMC). Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- Your personal information may be sent to our administrative processing centers in Mumbai (India) or Kuala Lumpur (Malaysia). It may also be sent to: Bermuda, Brazil, China, Dubai, Hong Kong, Ireland, Japan, Singapore, South Korea, United Kingdom and the United States for the purposes of outsourcing Insurance Broking, Intermediary and Risk Advisory Services; and Canada, India, United Kingdom and the United States for the purposes of outsourcing Business Support Services (for example, IT systems administration and payment processing).
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act, you must obtain it with the individual's consent.
- By providing this information, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement.
- If you do not provide all or part of the information requested, we may be unable to process your application or claim or provide other required services.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- We will use and disclose your personal information in accordance with our Privacy Policy. Our Privacy Policy can be accessed on our website (<https://www.echelonaustralia.com.au/privacy>).
- For further information contact your Account Executive, Claims Manager or our Privacy Officer at the following address:

Echelon Australia Pty Ltd, One International Towers, 100 Barangaroo Avenue, SYDNEY, NSW, 2000. Telephone: +61 (02) 8864 7688. Email: privacy.australia@marsh.com