

# TRAVEL INSURANCE CLAIM FORM

## Important Information

The provision of this form is not an admission of liability or acceptance of your claim.

To avoid delay in processing your claim please ensure all sections are completed and necessary documentation specified in the section relevant to your claim is sent with this claim form. This includes attaching travel documents such as itinerary and bookings.

The Privacy Consent must be completed for all claims.

**ReadySet Insurance** works with Corporate Services Network (CSN) to manage and settle claims on our behalf. CSN is our trusted claims partner, and they'll be your main point of contact throughout the process.

Need Help? Contact our team by phone (+61 2 8123 0493) or email ([readyssetclaims@gbtpa.com.au](mailto:readyssetclaims@gbtpa.com.au)).

**This form must be fully completed for the sections applicable to your claim and signed.**

Policy Holder Name:			
Policy Number:			
Period of Journey:	<div> <div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div> </div>	to	<div> <div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div> </div>
Name of Claimant:			<input type="checkbox"/> Mr <input type="checkbox"/> Mrs <input type="checkbox"/> Miss <input type="checkbox"/> Ms
Date of Birth:	<div> <div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div> </div>		
Address:			
Telephone:	Home:	Business:	Mobile:
Email Address:			

Did you use a credit card to purchase your travel (eg; flights, accommodation, tours)? Yes      No

If Yes, please complete the following:

Name on Credit Card:	
Name of Financial Institution:	

Card Type   ☐ Visa   ☐ Mastercard   ☐ Amex      Card Level:   ☐ Gold   ☐ Platinum   ☐ Other

Total Cost of Travel \$      Cost of Air Fares only:      \$

Amount Charged on Credit Card      \$

# Electronic Funds Transfer (EFT) details

Account Name

BSB (6 digits)

Account Number (up to 9 digits)

Bank Name

Branch

If you are unsure of any of your bank details, please contact your bank before adding here.

# Corporate Services Network (CSN)

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs).

CSN will ensure that all personal information held is treated in accordance with the Act and the APPs. All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at [www.csnet.com.au](http://www.csnet.com.au) and send to [privacy@csnet.com.au](mailto:privacy@csnet.com.au)

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

## Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN's Privacy Policy and this document.

In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits. I will use my best endeavours and render all reasonable assistance and cooperation to CSN in the assessment of my claim.

I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.

I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signed									
Date	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

# Section A – Benefits Applicable before or during travel

## Additional Accommodation & Travel Expenses, Family Emergency, Emergency Companions & Cancellation

### Supporting Documents

1. The Original Tickets/Vouchers if a refund is not obtainable.
2. Doctor's/Hospital Certificate specifying exact nature of condition suffered by Injured/Sick person.
3. Letter from Travel Agent or travel provider verifying total cost of journey, value of unused portion of journey, cancellation charges incurred and total amount of refund received.
4. If the cancellation is due to the unforeseeable death, accidental injury or illness of the claimant or the claimants relative: a detailed Medical report with a background to the condition suffered and/or treatment received. The Medical report should also advise when the condition leading to the claim first commenced, and details of any relevant medical history.

What was the reason you could not commence your proposed journey or complete the return flight?

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 so please complete the below

Name	Address	Relationship	Age

Nature of complaint preventing travel:

Date of first Medical Treatment:

Has the Injured/Sick person had a similar condition in the past? ☐ Yes ☐ No

Name and address of Patient's normal Doctor

Name:		Street Address:
Email Address:		

Date you advised Travel Agent/travel provider to cancel bookings (if applicable):

Amount of Deposit paid and date paid:	\$	Date: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Balance of Full Fare and date paid:	\$	Date: <input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>
Total paid:	\$	
Refund received on cancellation:	\$	
Full amount being claimed:	\$	(excluding any Insurance Premium)

Were any alternative arrangements offered or made (give details)?

☐ Yes☐ No

Were any additional fares incurred as a result of cancellation (give details)?

☐ Yes☐ No

Complete this section for additional expenses

Reason for incurring additional expenses or forfeiting travel or accommodation expenses

Details of expenses incurred / items claimed	
	\$
	\$
	\$
	\$

Were these expenses incurred as a result of Injury or Sickness as claimed on previous page?

☐ Yes☐ No

If these expenses were incurred as a result of Injury or Sickness to any other person, please give details of of the person and their relationship.

Name		Age	Relationship to Claimant
Address			
Cause			

Disruption of Journey - Non Medical

Supporting Documents

- 1. The Original Tickets/Vouchers if a refund is not obtainable.
- 2. Letter from Travel Agent or travel provider verifying total cost of journey, value of unused portion of journey, cancellation charges incurred and total amount of refund received.
- 3. Travel itinerary

What was the reason for the disruption/delay?

Description of the disruption/delay

Details of expenses incurred / items claimed	
	\$
	\$
	\$
	\$

# Section B – Medical Expenses during travel

Supporting documents

- 1. Original Doctor’s/Hospital accounts and receipts together with details relating to any medical benefit refunds.
- 2. Original Doctor’s Certificate verifying nature of complaint suffered by you.

Type of Injury or Sickness:	Date of Accident or Commencement of Sickness:								
	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

Injury – Give full details of Accident or Sickness:

Date of First Medical Consultation:	Name of Doctor or Hospital:								
<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	
D	D	M	M	Y	Y	Y	Y		

Details of other treatment by Doctors/Hospital:

Dates in Hospital:	Admitted	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="checkbox"/> am	<input type="checkbox"/> pm
D	D	M	M	Y	Y	Y	Y					
	Discharged	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	<input type="checkbox"/> am	<input type="checkbox"/> pm
D	D	M	M	Y	Y	Y	Y					

Have you ever suffered from the same or a similar complaint in the past?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, give details, dates, etc.		

Are you a member of a Private Health Insurance Fund ?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Name of Fund:

# Section C – Benefits applicable during or after travel

## Baggage & Personal Effects (including Travel Documents, Theft of Cash, Credit Cards and Winter Sports Equipment Hire)

### Supporting Documents

- 1. Report or letter from Authority (e.g. Police, Airline) regarding the loss.
- 2. Receipts, Instruction Manuals, Valuation Certificates, Credit Card Vouchers or other proof of purchase for items claimed.
- 3. Quotations for replacement of items claimed

Give full details of how loss damage or theft occurred: (Detail each event)

Date of occurrence:	<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	Time:	<input type="checkbox"/> am <input type="checkbox"/> pm
Date of loss reported	<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	Time:	<input type="checkbox"/> am <input type="checkbox"/> pm
Were articles lost by Carrier (e.g. Airline)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name:	

Have you yet 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? If so, give details and attach copies of correspondence.

NOTE: The Warsaw Convention imposes a liability upon the Carrier and you should claim on them first

Airline:	Claim No.:	
Are any of the items covered by other insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, which Company?
Were all the missing articles your property?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, who is the owner?

Description and size of suitcase in which missing goods carried:

Full details of articles claimed	Where purchased	Date of Purchase	Original Purchase Price	Replacement Amount Claimed	Remarks





Domestic Pets Cont'd

Are you claiming for additional fees as a result of a delay, or for an injury to your pet. ☐ Delay ☐ Injury ☐ Both

If claiming due to a delay what were the dates of your delay?

Delay from

D

D

M

M

Y

Y

Y

Y

Delay To

D

D

M

M

Y

Y

Y

Y

If claiming due to an injury – List the injuries suffered by your pet

Who was the pet in the care of at the time of the injury?

Domestic Services

Supporting Documents

1. Original Doctor’s Certificate verifying nature of complaint suffered by you and which confirms your disablement and the need for housekeeping services

Were these expenses incurred as a result of an Injury or Sickness as claimed on previous page? ☐ Yes ☐ No

If no, please complete all details below.

Type of Injury or Sickness:

Date of Accident or Commencement of Sickness:

D

D

M

M

Y

Y

Y

Y

Injury – Give full details of Accident or Sickness:

Date of First Medical Consultation:

D

D

M

M

Y

Y

Y

Y

Name of Doctor or Hospital:

Details of other treatment by Doctors/Hospital:

Dates in Hospital:

Admitted

D

D

M

M

Y

Y

Y

Y

☐ am ☐ pm

Discharged

D

D

M

M

Y

Y

Y

Y

☐ am ☐ pm

Have you ever suffered from the same or a similar complaint in the past? ☐ Yes ☐ No

If yes, give details, dates, etc.

Rental Vehicle Excess

Supporting Documents

- 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.
- 4. A copy of the Rental Vehicle Repair Invoice from Hire Company.

Which Police were advised? State Police Station and attach copy report if available.									
Date of Loss: <table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	Value of Excess/LDW:\$
D	D	M	M	Y	Y	Y	Y		

Please provide a full description of the circumstances that lead to the claim.

Details of claim:

# Section D - Optional Benefits

## Cruise Option - Pre-Paid Shore Excursions Cancellation & Cabin Confinement/Loss of Enjoyment

### Supporting Documents

- 1. Proof of your confinement and the reason for that confinement
- 2. Receipts for deposits paid, and confirmation these have not been refunded

Dates of Confinement

From

D

D

M

M

Y

Y

Y

Y

To

D

D

M

M

Y

Y

Y

Y

Reason for Confinement

Details of excursions claimed	Currency e.g. USD	Amount Paid	Refund Received

## Cruise Option - Missed Cruise Departure

### Supporting Documents

- 1. Written confirmation from the appropriate authority stating the full details of the accident
- 2. Receipts for expenses claimed

Description of the accident, including the departure missed and the port where you rejoined the cruise.

Details of expenses incurred / items claimed	
	\$
	\$
	\$
	\$

Cruise Option - Missed Port

Supporting Documents

- 1. Written confirmation from the appropriate authority confirming the reason for the missed port/s.
- 2. Your cruise itinerary

Description of the port/s missed and the reason.

Cruise Option - Formal Attire

Supporting Documents

- 1. Report or letter from Authority (e.g. Police, Airline) regarding the loss.
- 2. Receipts or other proof of purchase for items claimed.
- 3. Quotations for replacement of items claimed

Give full details of how loss, damage or theft occurred: (Detail each event)

Date of occurrence:	<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	Time:	<input type="checkbox"/> am <input type="checkbox"/> pm
Date of loss reported:	<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	Time:	<input type="checkbox"/> am <input type="checkbox"/> pm
Were articles lost by Carrier (e.g. Airline)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Name:	
Have you yet 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? If so, give details and attach copies of correspondence.			
Airline:		Claim No.:	
Are any of the items covered by other insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, which Company?	
Were all the missing articles your property?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If not, who is the owner?	

Formal Attire Cont'd

Full details of articles claimed	Where purchased	Date of Purchase	Original Purchase Price	Replacement Amount Claimed	Remarks

Cruise Option - Formal Attire Delay Allowance

Supporting Documents

- 1. Written confirmation of the delay from the carrier responsible for the delay
- 2. Receipts or other proof of purchase for items claimed.

Date you arrived:		Date your formal attire arrived:	
<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>		<div><div>D</div><div>D</div><div>M</div><div>M</div><div>Y</div><div>Y</div><div>Y</div><div>Y</div></div>	
How long was your formal attire delayed?		hours:	days:
Items purchased or hired	Currency e.g. USD	Refund Received	Amount Paid

Winter Sports Option -Ski Pack

Supporting Documents

- 1. Original Doctor’s Certificate verifying nature of complaint suffered by you
- 2. Receipts or other proof of purchase for items claimed.

Were these expenses incurred as a result of an Injury or Sickness as claimed on previous page? ☐ Yes ☐ No

If no, please complete all details below.

Type of Injury or Sickness:	Date of Accident or Commencement of Sickness: <table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

Injury – Give full details of Accident or Sickness:

Date of First Medical Consultation: <table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	Name of Doctor or Hospital:
D	D	M	M	Y	Y	Y	Y		

Details of other treatment by Doctors/Hospital:

Details of ski items claimed

Item	Date of Purchase	Purchase Price	Amount Claimed	Notes / Information

Winter Sports Option - Piste Closure and/or Bad Weather and Avalanche Closure

Supporting Documents

- 1. Written confirmation from the appropriate authority confirming the weather and/or closure and the duration of such closure.
- 2. Receipts or other proof of purchase for items claimed

Description of the reason for closure

Closure Dates	From	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	To	<table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y													
D	D	M	M	Y	Y	Y	Y													

Winter Sports Option - Winter Sports Equipment Excess

Supporting Documents

- 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.
- 4. A copy of the Repair Invoice from Hire Company.
- 5. Original Doctor's certificate advising you are unfit to return the hire equipment (if return costs claimed)

If stolen, which Police were advised? State Police Station and attach copy report if available.									
Date of Loss: <table><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y	Value of Excess: \$
D	D	M	M	Y	Y	Y	Y		

Please provide a full description of the circumstances that lead to the claim.

Additional Costs Claimed :		
Item	Amount Claimed	Notes / Information

Please submit your claim form and supporting documents to:

Email: [readysetclaims@gbtpa.com.au](mailto:readysetclaims@gbtpa.com.au)  
Telephone: +61 2 8123 0493

Please ensure you have completed all sections of the claim form and you have attached all documentation required to support your claim. Failure to provide supporting documentation may result in delays in processing your claim. If you cannot provide any of the documentation requested please advise the reason:

PLEASE KEEP A COPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORDS