

**CORPORATE
SERVICES
NETWORK**



Liberty
Specialty Markets

TRAVEL INSURANCE

Important Notice

This form must be fully completed in the sections applicable to your claim and signed. Please ensure all supporting information is provided with your claim form otherwise there may be delays in processing.

Please keep a photocopy of all documentation you send us for your own record.

The Medical Authority and Declaration section must also be signed for all claims.

The issue of this form is not an admission of liability by the company or a waiver of its rights.

1. YOUR DETAILS

All questions in this section must be answered

Employer/company			
Policy no			
Business unit name			
Name		Male	Female
Nationality		Date of birth	
Address			
		Country	
Telephone home	Telephone work	Mobile	
Do you consent to us communicating with you by email?	Yes	No	Email

2. BANK DETAILS

Bank name	
Bank address	
BSB (Branch) account	Account no
Account holder's name	Swift code
IBAN no	Currency

3. TRAVEL INFORMATION AND AUTHORISATION

Travel details	Departure date	Return date
Proposed dates of travel		
Actual dates of travel		
Country or countries to be visited		
Type of travel? (Please select one or more)	Air	Sea
	Rail	Bus
		Hire Car
Reason for travel		

Travel approval

This section to be completed by an Authorised Company Representative who can approve the above listed travel

Last name	First name	Middle name initial
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I agree that the above listed travel is authorised by my Company

Signature

4. CLAIM FOR CANCELLATION OR CURTAILMENT AND/OR LOSS OF DEPOSITS

Does your claim arise as a result of sickness, injury or accident to yourself? Yes No

Does your claim arise as a result of sickness, injury or accident to some other person or relative as defined in the policy? Yes No

If yes please state

Name	Relationship	Age
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Address _____

If your claim does not arise as a result of sickness, injury or accident, describe the reason for your claim

Date you advised Travel Agent to cancel bookings _____

Has all or part of your travel been paid for? All Part (If 'All' go to Q.3 below)

1. Amount of deposit paid	Date paid
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2. Balance of full fare paid	Date paid
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3. Total cost of travel	
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Value of forfeited portion of journey (if applicable) _____

Refund received on cancellation _____

Full amount of booked travel being claimed _____

Were any alternative arrangements offered? Yes No

If yes, give details

Did you accept any alternative arrangement? Yes No

Have you incurred any additional fares? _____

Total amount being claimed (you must specify the currency of your claim if not AUD)

The following items must be included with this claim (photocopies can be submitted, in the case of originals, keep copies).

- Receipts and/or tickets relating to original and any additional expenses incurred
- Proof of cause i.e. Original Doctor/Hospital certificate relating to injured or sick person or letter relating to cancellation, curtailment or diversion of scheduled public transport

5. CLAIM FOR PERSONAL ACCIDENT OR SICKNESS

Does your claim arise from an accident, injury or sickness while you were travelling? Accident Injury Sickness

Date of accident, injury or onset of sickness

If sickness – type of sickness, describe

If injury – give full details of accident, or injury occurrence

Describe the treatment received

Name and address of treating doctor/hospital/clinic

Date of treatment or treatments

Country/countries where you were treated

Amount or amounts claimed – specify currency

If sickness – have you ever suffered from the same or similar condition in the past? Yes No

If Yes, give details, dates, names and addresses of treating physicians

Are you a member of a private health insurance fund? Yes No
 If applicable all medical accounts must first be lodged with your private health fund.

Name of fund

If you are a Citizen or Resident of the United States, are you eligible for US Medicare benefits? Yes No

The following items must be included with this claim (photocopies can be submitted, in the case of originals, keep copies).

- Original Doctor/Hospital accounts and receipts together with statements from Medicare and Private Health Funds
- Original Doctor's certificate
- Any medical, x-ray or test reports

6. CLAIM FOR LOSS OR DEPRIVATION OF LUGGAGE/PERSONAL EFFECTS/ ELECTRONIC EQUIPMENT/MONEY OR DOCUMENTS

Type of claim – Select one or more Loss Deprivation Damage Theft

Date of the event Time of the event AM PM

Please provide full details of how this loss, deprivation, damage or theft occurred

Were articles lost or damaged by the carrier? Yes No

If Yes, name the carrier

Was the event reported? Yes No

If this is a deprivation claim, state date and time when items were returned to you

Date items were returned Time items were returned AM PM

* Have you made a claim or complaint against any Carrier/Airline Hotel or other authority or against any individual responsible for the loss or damage to your property? Yes No

If so, attach details and copies of correspondence.

Note: The Warsaw/Montreal Convention imposes a liability upon the carrier and you should claim on them first.

Are any of the items covered by other insurance? Yes No

If Yes, which insurer Policy no

List of items claimed for

Item description	Name and address from where items were purchased	Original date of purchase	Original purchase price (specify currency)	Amount claimed (specify currency)

(if insufficient space attach separate sheet)

7. CLAIM FOR EMERGENCY EXPENSES/MISSED TRANSPORT/CANCELLATION OR CURTAILMENT DUE TO UNFORESEEN EVENT

Reason for incurring additional travel or accommodation expenses

List the country or countries in which you incurred the costs

List specifically the additional TRAVEL expenses (specify currency)	Amount claimed
Total	

List specifically the additional ACCOMMODATION expenses (specify currency)

Total	

List specifically the other EMERGENCY expenses (specify currency)

Total	

Were these expenses incurred as a result of injury or sickness as claimed in Section 5? Yes No

The following items must be included with this claim (photocopies can be submitted, in the case of originals, keep copies).

- Receipts/Invoices and/or tickets relating to additional expenses incurred
- Doctor/Hospital certificate specifying exact name of condition suffered by any injured/sick person
- Letter from the travel agent or carrier confirming the reason for additional expenses and/or any refund applicable

8. CLAIM FOR RENTAL VEHICLE EXCESS WAIVER

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

The following items must be included with this claim (photocopies can be submitted, in the case of originals, keep copies).

- The Vehicle Rental Agreement
- Notice from the rental company in respect of the excess or deductible
- Documentation evidencing payment of excess or deductible

9. CLAIM FOR PERSONAL LIABILITY

Bodily injury – Provide relevant details – name and address of injured party and details of injury (use separate sheet if insufficient room)

Damage to property – List all property damage together with name and address of party claiming damage against you (use separate sheet if insufficient room)

Is the injury or damage related to a travelling companion?	Yes	No
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Do you consider you were at fault?	Yes	No
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If so, why?

Were these expenses incurred as a result of injury or sickness as claimed in Section 5?	Yes	No
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The following items must be included with this claim (photocopies can be submitted, in the case of originals, keep copies).

- Letter or document and all details of the claim made on you

10. MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither Corporate Services Network (CSN) or Liberty Specialty Markets (Liberty) have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN or Liberty using and disclosing my personal information pursuant to their 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 or Liberty such personal information (including health information) as CSN or Liberty 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 or Liberty 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.

Signature of claimant

Date

Name of claimant

Signature of witness (any adult person)

Date

Name of witness

Privacy Notice

Liberty Specialty Markets (Liberty) and Corporate Services Network (CSN) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information. For the purposes of this Privacy Notice, 'we', 'us' or 'our' refers to, if the context permits, both Liberty and CSN.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and CSN collects personal information in order to provide claim assessments and insurance related services. Liberty and CSN may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, UK, Singapore, Hong Kong and Malaysia.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from Liberty and CSN. If you do not provide the personal information Liberty, CSN or other relevant third parties require to offer you specific products or services, Liberty or CSN may not be able to provide the appropriate type or level of service.

If you wish to gain access to or correct your personal information, make a privacy complaint, or if you have any query about how Liberty or CSN collects or handles your personal information please write to Liberty's Privacy Officer at privacy.officer.ap@libertyglobalgroup.com or call +61 2 8298 5800 and/or CSN's Privacy Officer at privacy@csnet.com.au or call +612 8256 1770.

To obtain a copy of Liberty's Privacy Policy go to Liberty's website (libertyspecialtymarkets.com.au) or request a copy from Liberty's Privacy Officer. To obtain a copy of CSN's Privacy Policy go to CSN's website (csnet.com.au) or request a copy from CSN's Privacy Officer.

When you give Liberty or CSN personal or sensitive information about other individuals, Liberty and CSN rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.