

**Postal Address:**  
Worldcare Claims  
PO Box 162  
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— a company of the  **MONDIAL ASSISTANCE** group —

Underwritten by Allianz Australia Insurance Ltd  
ABN 15000 122 850

Phone: 1800 077 522  
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**YOUR RIGHTS & YOUR PRIVACY**

If you are in any way dissatisfied with our handling of your claim you should discuss your concerns with the person who dealt with your claim. If you remain dissatisfied you may request our Claims Manager to review your claim and if the dispute is not resolved you have the right to have the matter reviewed by the insurance company's Internal Dispute Resolution Scheme. If you are still unhappy you can have your claim reviewed by the General Insurance Claims Review Panel, an independent body which can make decisions binding on the insurance company.

The information that you provide is collected for the purpose of determining any claims you may make on your policy. Worldcare may need to request information from, or disclose information to, medical practitioners, hospitals, international assistance providers, underwriters or its agents, other insurers and/or insurance reference bureau in order to process your claim.

- Please use block letters.
- Please retain a copy of all documents for your records.
- Please attach original receipts, accounts and other documents.

**CLIENT DETAILS**

Certificate No: .....

Claim No: .....  
(Office Use Only)

A copy of the certificate must be attached. If you do not have a copy please obtain one from the issuing agent before submitting your claim.

Mr  Mrs  Ms  Miss  Other .....

Surname of policy holder/s: ..... Given Name/s: ..... Date of birth: ...../...../.....

Address: ..... Postcode: .....

Occupation: ..... Telephone: H ( ) ..... W ( ) .....

Email: .....

Name of travel agency: ..... Location: ..... Consultant: .....

Date travel arrangements booked: ...../...../..... Date of departure: ...../...../..... Date of return: ...../...../.....

Have you made previous claims with respect to travel insurance? YES  NO

If yes, give details: .....

Are you able to claim through any other source? YES  NO

(e.g. credit card provider, airline etc.)  
If yes, give details and include evidence of the amount received: .....

**DECLARATION** I/We declare that all statements and particulars contained on this claim form are true and correct. I/We acknowledge that the underwriter or its agents may give to and obtain from other insurers and/or insurance reference bureau, personal information relating to this claim.

SIGNATURE OF POLICY HOLDER: ..... Date: ...../...../.....

**MEDICAL, ADDITIONAL EXPENSES AND/OR CANCELLATION CLAIMS**

Date of incident: ...../...../..... Time: ..... am/pm Country: .....

Cause of claim (include details of illness/injury): .....

1. If your claim results from **your** state of health **or** another person's state of health:

a) i) Name of person: ..... Date of Birth: ...../...../.....

ii) Relationship of person to policy holder: .....

iii) Has the illness/injury occurred before? YES  NO

If yes, give details: .....

iv) If an injury, how was the injury caused? .....

b) If you are claiming because you cancelled or postponed your trip prior to departure, you should have the Medical Certificate on Page 4 completed by the usual doctor of the person whose state of health caused your claim.





**To be completed by the person whose state of health caused the claim:**

I authorise the underwriter or its representatives to obtain from any person or organisation any information in respect of treatment for the condition/s which resulted in this claim. I acknowledge that a photostat copy of this authorisation shall be considered as valid as the original.

Signature of patient: ..... Print Name: .....  
Name of usual doctor in Australia: ..... Doctor's phone number: ( ) .....  
Doctor's address: ..... Postcode: .....

**PLEASE INDICATE YOUR PREFERRED METHOD OF PAYMENT**

Note that for an unpaid account the cheque will be issued to the provider.

Direct Credit to your Name of Bank: \_\_\_\_\_  
BSB Number:    
Account Number:   
 By cheque to your postal address

**MEDICAL CERTIFICATE**

(For completion by the patient's usual doctor)

To be obtained at the claimant's expense from the patient's usual doctor in all cases of cancellation and medical claims resulting from accident, illness or death.

**IMPORTANT** The medical attendant is respectfully requested to give as much detail as possible in order to assist our client and avoid the necessity of additional enquiries.

**"PLEASE USE BLOCK LETTERS"**

- Name of person to whom this certificate applies (i.e. the person whose state of health caused the claim):  
..... Date of birth: ...../...../.....
- Are you the patient's usual medical attendant? If yes, for how long?  
.....
- Please give precise details of the nature of the illness or injury which gave rise to this claim:  
.....  
.....
- What was the date of onset of the illness or the date the injuries were received? ...../...../.....
- What was the date you first investigated or were consulted by the patient for this condition? ...../...../.....
- Has the patient previously been investigated, diagnosed or treated in respect of the same/similar/related illness or injury as described in question 3?  
.....  
If yes, when was the last time, prior to the occurrence which gave rise to this claim, and what treatment and/or medication was prescribed?  
.....  
Was the patient advised to continue this treatment and/or medication whilst on the journey?  
.....
- Are you prepared to certify that solely due to the condition described in Question 3, the claimant/s was/were compelled to cancel the travel arrangements?  
.....
- Did you recommend that all travel be cancelled because of their illness/injury described in Question 3?  
.....

I certify that the statements contained in this Medical Certificate are true and correct.

Doctor's signature: ..... Date: .....  
Name: ..... Qualification: .....  
Address: ..... Postcode: .....  
Telephone: ( ) ..... Facsimile: ( ) .....