Claim form

Travel Insurance

At Liberty, we're here to support you throughout the claims process. We're committed to handling your claim with efficiency, honesty and fairness.

This claim form includes several sections for you to complete. To help us assess your claim promptly, please answer all relevant questions and provide the requested supporting documentation.

Helpful instructions

Documentation — Keep a copy of all of documentation you send us for your own records:

- Documentation included with this claim can be submitted as copies
- If sending original documentation, please keep copies.

Page 2 — The questions on page two (2) **are mandatory**. Please ensure that you:

- **Fully** complete page two (2), and then the sections relevant to your claimed event.

Sections 1 - 7 — Ensure you include the following documentation to support your claim:

- Original doctor/hospital accounts and receipts
- Original doctor's certificate plus any medical, x-ray or test reports
- A letter from the travel agent or carrier confirming the reason for additional expenses and/ or any refund applicable
- Receipts/invoices and/or tickets relating to additional expenses incurred.

Section 8 — Please sign Section 8, Medical Authority and Declaration, for all claim submissions.

Neither the issue of this form nor its completion is to be deemed a provision of indemnity or an admission of liability.

Ready to submit your claim form?

If so, please double check that you have followed all of the instructions, then send the completed claim form to ClaimsAusAH@libertymutual.com

Save Print

Liberty
c/- GPO Box 4276, Sydney NSW 2001

T: +61 2 9959 4307
F: +61 2 9959 4308
E: ClaimsAusAH@libertymutual.com

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Page two (2) mandatory questions. Please fill out this page completely, and then the sections of the form that are applicable to your claim.

YOUR DETAILS

Employer/company

Policy number | Position held

Title | Given name/s | Male ☐ Female ☐ Prefer not to state ☐

Family name | Date of birth

Residential address

Suburb | State | Country | Postcode

Postal address (if different to above)

Nationality

Telephone home | Telephone work | Mobile

Do you consent to us communicating with you by email? Yes ☐ No ☐

If yes, please provide your email address

BANK DETAILS

Bank name

Bank address

BSB (Branch) account ☐☐☐ ☐☐☐ | Account no ☐☐☐☐☐☐☐☐☐

Account holder's name | Currency

IBAN no (if international bank account) | Swift code

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 ☐

Please state your reason for travel including business, leisure or a combination of both:

TRAVEL APPROVAL – TO BE COMPLETED BY EMPLOYER

This section to be completed by an authorised company representative who can approve the above listed travel

Last name | First name

I declare that the above listed travel arrangements were approved prior to departure

Signature | Position held | Date

Liberty means Liberty Mutual Insurance Company, Australia Branch (ABN 61 086 083 605) incorporated in Massachusetts, USA (the liability of members is limited). Claims are managed by Gallagher Bassett Accident & Health Pty Ltd (AR No. 001294637) as Authorised Representative of Gallagher Bassett Services Pty Ltd (AFSL No. 530867).

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1. CLAIM FOR OVERSEAS MEDICAL EXPENSES

Does your claim arise from a bodily injury or sickness during your journey? Injury ☐ Sickness ☐

Date of injury or onset of sickness

If sickness, please state the diagnosis or symptoms suffered:

If bodily injury, give full details of accident or injury occurrence:

List the treatment/s, date/s it was received, and the country in which the treatment took place:

Treatment	Date	Country

Please provide the name and address of treating doctor/s/hospital/s or clinics:

Name and address	Country

Have all invoices been paid by you? Yes ☐ No ☐

If no, please state outstanding amounts and specify the currency

Service provider	Currency	Outstanding amount

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

Date	Treatment	Name of physician	Address of physician

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
– Original doctor's certificate
– Any medical, x-ray or test reports
– Private health fund statement (if applicable)

2. CLAIM FOR LOSS OF DEPOSITS, CANCELLATION, DISRUPTION AND CURTAILMENT

Does your claim arise because of sickness, an injury or accident to yourself? Yes ☐ No ☐

Does your claim arise because of sickness, an injury or accident to some other person or relative? Yes ☐ No ☐

If yes, please state:

Name Relationship to you Age

Address

If your claim **does not** arise because of sickness, an injury or accident, please describe the reason for your claim:

What is the date you advised the travel agent or service provider to cancel or amend the booking/s

Has all, or part of, your travel been paid for? All ☐ Part ☐

	Currency	Amount	Date paid
Amount of deposit paid			
Balance of full fare paid			
Total cost of travel			
Value of forfeited portion of journey (if applicable)			
Refund received on cancellation			
Amount of booked travel being claimed			

Were any alternative arrangements offered? Yes ☐ No ☐

If yes, please give details:

Did you accept the arrangements offered? Yes ☐ No ☐

	Currency	Amount
Total amount being claimed (specify the currency of your claim)		

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
– Proof of cause i.e., original doctor/hospital certificate relating to the injured or sick person, or letter relating to cancellation, curtailment, or diversion of scheduled public transport.

3. CLAIM FOR EMERGENCY EXPENSES/MISSED TRANSPORT OR CURTAILMENT DUE TO AN UNFORESEEN EVENT

Please provide a detailed description of events

List the country or countries in which you incurred the costs

List specifically the additional **travel** expenses	**Specify currency**	**Amount claimed**
	Total	0

List specifically the additional **accommodation** expenses

	Total	0

List specifically the other **emergency** expenses

	Total	0

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, service provider or carrier confirming the reason for additional expenses and/or any refund applicable.

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4. CLAIM FOR BAGGAGE, MONEY AND OTHER ITEMS

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 to the carrier or other local authority, such as the hotel/police? Yes ☐ No ☐

If this is a deprivation claim, please state the date and time when the 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 yes, please 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 number

List of items claimed. Proof of purchase is required for each item.

Item description	Name and address from where items were purchased	Original date of purchase	Original purchaseprice	Amount claimed	Item replaced?
			Currency: Amount:	Currency: Amount:	Yes ☐ No ☐
			Currency: Amount:	Currency: Amount:	Yes ☐ No ☐
			Currency: Amount:	Currency: Amount:	Yes ☐ No ☐
			Currency: Amount:	Currency: Amount:	Yes ☐ No ☐
			Currency: Amount:	Currency: Amount:	Yes ☐ No ☐
			Currency: Amount:	Currency: Amount:	Yes ☐ No ☐
			Currency: Amount:	Currency: Amount:	Yes ☐ No ☐

(If insufficient space, attach separate sheet.)

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5. CLAIM FOR PERSONAL ACCIDENT OR SICKNESS

Were you temporarily unable to engage in your usual employment due to the bodily injury or sickness sustained during your journey, as described in Section 1? Yes ☐ No ☐

If no, go to next applicable section.

Does your claim arise from an injury or sickness while you were travelling? Yes ☐ No ☐

Please state the date of injury or onset of sickness

On what date were you due to resume your usual employment after the journey?

Provide the date/s the treating doctor medically certified you unfit from your usual duties? (To be supported by medical certificates and reports.)

Describe the treatment received during your inability to attend your employment

Name and address of the treating doctor/hospital/clinic

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

If yes, please provide details, including dates, names and addresses of treating physicians:

Are you a member of a private health insurance fund? Yes ☐ No ☐

Name of fund

The following items must be included with this claim (photocopies can be submitted; in the case of originals, keep copies):
– Payslips for the 12 months preceding the date of sickness/injury
– Original doctor's certificate and any medical reports
– Any medical, x-ray or test reports

6. CLAIM FOR RENTAL VEHICLE EXCESS

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

Date items were returned Time items were returned AM ☐ PM ☐

Type of non-commercial rental vehicle Station wagon ☐ Hatchback ☐ 4WD ☐ Other ☐

Please provide full details of the circumstances resulting in the damage/theft of the vehicle:

a. How did the incident occur?

b. Where did the incident occur?

c. Who was driving at the time of the incident?

d. Were you at fault?

e. Do you have any additional information to share? If so, please provide the details below:

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 charged
– Documentation evidencing payment of excess
– Incident report if applicable
– Police report if applicable

7. CLAIM FOR PERSONAL LIABILITY

Bodily injury – please provide relevant event details, including the name and address of any injured party and details of injury (use separate sheet if insufficient room)

Damage to property – please provide details of the property damaged together with the name and address of the party claiming damage against you (use separate sheet if insufficient room)

Is the injury or damage related to a travelling companion? Yes ☐ No ☐

Do you consider you were at fault? Yes ☐ No ☐

Please explain why:

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 against you

8. MEDICAL AUTHORITY AND DECLARATION

I consent to Liberty and their representatives using my personal information, health and other sensitive information and sharing it with their affiliated companies, service providers, insurance intermediaries, insurers, reinsurers, investigators, claims assessors, and other relevant third parties, only to the extent required for processing and handling my claim including assessment of eligibility and the provision of policy benefits, risk assessment, policy administration, and other insurance and related business purposes described in Liberty's privacy policy. I understand there may be circumstances in which I shall be contacted if my further consent is required to collect, use or disclose my personal information.

I authorise each person or entity including my service provider, healthcare provider, public authority, employer, witness, agent, next of kin, and another third party, to provide to Liberty and their representatives such information about me as may be requested in connection with my claim.

I appoint Liberty to do such act/s and execute such document/s on my behalf as is necessary or expedient to give effect to the consent and authorisation given by me in this form.

This consent, authorisation and appointment will remain in effect until completion of the relevant purpose or until altered or revoked (in whole or in part) by me, which I am free to do at any time by notice. However, I understand that without the consent, authorisation and appointment, Liberty's ability to provide services to me may be limited.

I confirm that any information provided by me is true, correct, complete and not misleading, and if I provide information about others, I will only do so with their knowledge and consent.

I understand that unless expressly otherwise stated in writing, neither Liberty or their representatives make any representation, accept any liability or claim or waive any right or defence.

By signing below, I give effect to the declarations, consent, authorisation and appointment set out in this form.

Signature of claimant | Date

Name of claimant

Signature of witness (any adult person) | Date

Name of witness

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Privacy Notice

Liberty Mutual Insurance Company, Australia Branch (ABN 61 086 083 605) incorporated in Massachusetts, USA (the liability of members is limited) (**Liberty, we, our**) is part of the Liberty Mutual Group headquartered in the United States.

Liberty Australia's head office contact details are:
Mailing address: The Privacy Officer, Liberty Mutual Insurance Company, Australia Branch, Level 38, Governor Phillip Tower, 1 Farrer Place, Sydney NSW 2000
Phone: +61 2 8298 5800

Liberty is bound by the Privacy Act 1988 (Cth) and the Australian Privacy Principles when it collects and handles your personal and sensitive information.

We collect personal and sensitive information to provide insurance and related products and services. This may include information relating to your identity, personal circumstances, employment, health, personal or professional risk information, insurance requirements and similar information collected from you, the insured, policyholder, insurance broker or another intermediary. Liberty will use your information for activities such as identity check, underwriting, claims management, eligibility assessment, provision of policy benefits, risk assessment, policy administration, reserving, settlement, business analysis, information management and automation, and other insurance and related business purposes.

If you provide Liberty with your sensitive information for insurance purposes or if you instruct a third party to do so, you consent that Liberty may handle your sensitive information as is necessary for these activities. You may withdraw your consent at any time. If we do not obtain the required information, we may be unable to provide appropriate cover or service.

If you provide Liberty with personal or sensitive information about another individual, you must ensure they are aware of this notice and have consented to the disclosure. If you have not done so, please inform Liberty before sharing their information.

Your personal information may be disclosed where it is lawful, necessary and proportionate to do so, to Liberty's affiliated companies, our service providers, brokers and other insurance intermediaries, insurers, underwriters, reinsurers, investigators, claims assessors, loss adjusters, legal and professional advisors, parties to a claim, health service providers, witnesses, policyholder, beneficiaries, public authorities, and other relevant third parties. Some recipients may be located overseas in Canada, China, European Union, Hong Kong, India, Malaysia, Singapore, United Kingdom, and the United States. We take reasonable steps such as binding the recipient to appropriate contractual terms to ensure that your personal information remains protected in these countries.

We rely on enterprise technologies including artificial intelligence for various tasks including data extraction, summarisation, analysis, process automation and others. However, decisions based on your personal information that affect you are made by our staff and not by automated means.

You may access or seek correction of your personal information, make a privacy complaint, or raise any queries by contacting Liberty's Privacy Officer: privacy.officer.ap@libertymutual.com.

For more information, please visit our Privacy Policy.

Please see below the details of our claims service provider:
Company name: Gallagher Bassett Accident & Health Pty Ltd (Company)
Email: privacy@gbtpa.com.au Telephone: 1300 975 609 Mail: GPO Box 4276, Sydney NSW 2001
Privacy policy: https://www.gallagherbassett.com/au/global-privacy-notice/

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