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TRAVEL CLAIM FORM

(The issue of this form is not an admission of liability)

Trust Name:	**CSI Member Benefits Discretionary Trust**
ABN:	**56 279 303 288**

This form should be completed and forwarded to - ECHELON CLAIMS SERVICES
Please tick boxes where appropriate

1. Travellers Details

Full Name:		
Residential Address:		
State:	Postcode:	Telephone No:
Occupation:		
Date of Birth:	Sex: Male ☐ Female ☐	Mobile No:

2. Travel Agent

Name of Agent:	
Telephone No:	Date of Booking:
Date of Departure:	Date of Return:
Have you made previous claims for travel insurance?	Yes ☐ No ☐
If YES, please give details:	

Name of Insurer	Date of Claim

3. GST

Are you registered for GST?	Yes ☐ No ☐
If YES, please enter the Australian Business Number (ABN) and Input Tax Credit (ITC) entitlement percentage below:	
ABN No.	ITC % (at start of current period of cover)

If you fail to advise the availability of an Input Tax Credit or understate its availability, then you may have a liability to pay tax on the claim payment.
IMPORTANT – If more than one named insured is claiming for the loss, please supply details of ABN and ITC percentages applicable to each entity on a separate page and attach to claim form.

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A. Cancellation Claims

The following documents are required in support of your claim. Please attach to claim form.

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

Date of cancellation:

Reasons for 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?

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Which responsible authority e.g. Police was notified?	Date Notified:
Location:	Time: am/pm
Are your home contents insured?	Yes ☐ No ☐
Name of Insurer:	Policy No:
Are you a member of a Private Health Fund?	Yes ☐ No ☐
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 ☐
- Accounts in support of accommodation expenses ☐
- Medical certificates supporting need for altered travel plans ☐
- Copy of Travel itinerary ☐

Date of accident/illness circumstances:

Country:	Time: am/pm

Particulars of Claim:

If your claim arises from injury or illness, please specify the nature of such injury or illness:

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Name of person whose injury or illness caused additional expenditure:	
Their relationship to you:	
Has the injury or illness occurred before?	Yes ☐ No ☐
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)		

4. 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.

Name of usual Doctor:

Address of usual Doctor:

State: Postcode:

Telephone No:

5. Physician's Statement attached – Must be completed by Doctor

AUTHORITY & DECLARATION

I 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 agree that a Photostat copy or facsimile copy of this authorisation shall be considered as effective and valid as the original.

I/We do hereby declare that the foregoing answers are true and correct, that I/we have in no manner caused the said injury or sickness or, by any fraud or wilful misrepresentation sought unjustly to benefit by the said event and that the information detailed above is a true and faithful account of the actual injury/sickness sustained. AND I/we 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 **DO NOT AGREE** to the information contained herein (including my 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 CSI to assist in the management of this claim and the administration of the Trust.

☐ I/We **DO NOT AGREE** to the information contained herein (including my personal information) being shared with my current employer to assist in the management of this claim.

Banking Details

BSB: ____________________

Account Number: ____________________

Account Name: ____________________

Email Address: ____________________

Please Print Name:

Signature: **Dated:**

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

Echelon Claims Services
A division of
Echelon Australia Pty Ltd
ABN 96 085 720 056

GPO Box 1693, Adelaide, South Australia 5001

Email: ecssa@echelonaustralia.com.au
Freecall: 1800 640 009

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To be completed by your attending physician

ATTENDING PHYSICIAN'S STATEMENT

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

Patient's Name:

Patient's Address:

1. When did the patient suffer the injury? (enter date)
2. What were the circumstances surrounding the injury?
3. When did the patient first receive medical treatment?
4. Please give a complete diagnosis of this condition.
5. Please give results of any objective findings – (Detail tests done and findings)

	Test	**Findings**
1.	X-Rays	
2.	Other Tests	

6. Was the patient confined to hospital? Yes ☐ No ☐

   If YES, please advise :

   a. Name and address of hospital

   b. Period of confinement From To

7. What other treatment has the patient undergone?
8. What other treatment is required?

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History

1.	(a)	Was there a previous history or a similar condition?	Yes ☐ No ☐
	(b)	If YES, please state condition and advise when previous treatment was given	
2.	(a)	How long have you know the patient?	
	(b)	Are you the regular General Practitioner?	Yes ☐ No ☐
		If NOT, please advise who is:	

Degree of Disability

1.	When was the patient obligated to cease school?	
2.	If patient is still unfit for school, when approximately will the patient be able to resume?	
3.	If patient has recovered, when was patient able to resume school?	
Are there any underlying conditions affecting recovery from the current condition?		Yes ☐ No ☐
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 ☐ No ☐
If YES, please explain, giving estimated percentage of loss of function?		

Doctor's Name: **(please print)**	**Qualifications:**
Doctor's Address: **(please print)**	**Telephone No:**
Signature:	**Dated:**

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 centres 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