CORPORATE SERVICES NETWORK

Liberty Specialty Markets

TRAVEL INSURANCE

About this claim form

- To avoid delays with your claim, it's important that you provide answers to the applicable sections, including any additional documentation requested.
- The provision of this form is not an admission of liability.
- You can fill out the form either electronically or by hand and if you have any questions regarding its completion, please contact CSN on +61 2 8256 1770.

Helpful instructions

We know that making a claim is often done at a stressful time and understand the importance of processing your claim as quickly as possible. Your claim will be managed by Corporate Services Network (CSN), our trusted claims service provider, who is committed to ensuring your claim is handled efficiently, honestly, and fairly.

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.

Ready to submit your claim form?

If so, to avoid any delays, please double check that you have followed all the instructions, then save, print and scan the completed claim form and email it to liberty@csnet.com.au

Save Print

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E: liberty@csnet.com.au

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 SDA Church (Division Services) Ltd

Policy number 2000380058 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

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		0.00

List specifically the additional **accommodation** expenses

Total		0.00

List specifically the other **emergency** expenses

Total		0.00

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.

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 purchase price	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.)

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 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 any 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 Policies 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 their absolute discretion consider relevant for the 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 and Declaration.

Signature of claimant	Date
Name of claimant	

Signature of witness (any adult person)	Date
Name of witness	

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