

TRAVEL CLAIM FORM

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

Trust Name: JLT (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.

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?

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

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.

"We the undersigned hereby acknowledge and agree to the information contained herein (including our personal information) being shared with the other members of our JLT Discretionary Trust (Trust) as part of the Trust's Risk Management processes and reporting criteria".

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
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Freecall: 1800 640 009

History		
1.	(a) Was there a previous history or a similar condition?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	(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 <input type="checkbox"/> No <input type="checkbox"/>
	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 <input type="checkbox"/> No <input type="checkbox"/>
	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 <input type="checkbox"/> No <input type="checkbox"/>
	If YES, please explain, giving estimated percentage of loss of function?	
Name (please print)	Dated	Signed
Name (please print)	Street Address	City/Town
State	Postcode	Telephone No



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 subsequent amendments), we Echelon Australia Pty Ltd (Echelon), including Echelon Claims Services, draw your attention to the following:

- We may collect personal information about you.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other Echelon products or services. If you are proposing for or renewing insurance or membership, or membership of a Jardine Lloyd Thompson Discretionary Trust Arrangement (JDT Arrangement), the information is required pursuant to your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth), the Marine Insurance Act 1909 (Cth) or at common law.
- 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 Echelon related Group companies, such as Jardine Lloyd Thompson Pty Ltd (JLT). Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- 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 provide other required services, your application for insurance or membership of a JDT Arrangement may be declined or you may prejudice your insurance cover or cover under a JDT Arrangement.
- 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 1988 (Cth).
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- 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 1988 (Cth), you must obtain it with the individual's consent.
- Our Privacy Policy can be made available on request or can be accessed on JLT's website www.au.jlt.com
- For further information regarding Echelon's Privacy Policy, contact your Account Executive, Claims Manager or the Privacy Officer for JLT and Echelon.

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