NEW ZEALAND POLICE

Long Term Travel and Expatriate **Claim Form**

Allianz Global Assistance

This travel insurance is issued and managed by AWP Services New Zealand Limited trading as Allianz Global Assistance and is underwritten by Allianz Australia Insurance Limited trading as Allianz New Zealand.

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Policy No:	Claim No:
200000000	

PRIVACY The Privacy Act 1993 requires us to tell you that Allianz Global Assistance as agent for Allianz collect your personal information in order to handle your claim. We may disclose your personal information to third parties such as other insurers, travel agents, medical practitioners, intermediaries, loss adjusters, external claims data collectors, investigators, fraud detection, investigation or prevention agencies or as required by law. You have the right to seek access to and correct your personal information at any time. Please contact Allianz Global Assistance on 0800 630 117 for access.

Claimant Details

Name of Claimant (Mr/Mrs/Miss/Ms)		
Address		Postcode
Telephone Home	Business	Mobile
Email Address		
Date of Birth / /	Occupation	
Travel Agent	Date of Booking Travel Arrangements / /	
Date of Departure / /	Date of Return / /	
☐ I / we authorise my travel agent to act on my behalf if required for this claim.		
Please confirm if claim occurred during Business days ☐ Leisure days ☐		

Broker Details

Broker Name	
Address	Postcode
Phone	Mobile

Travel Arrangements

1. Did you use a credit card to purchase your travel (eg. flights, accomodation, tours)? ☐ **Yes** ☐ **No**
2. If ***Yes***, please complete the following:

Name on Credit Card	Name of Financial Institution
Card Type: ☐ Visa ☐ Mastercard ☐ Diners ☐ Amex	**Card Level:** ☐ Gold ☐ Platinum ☐ Other:

Section A. Expatriate Overseas medical , Dental and/or Hospitalisation CLAIM
THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Medical/Hospital/Dental Report detailing Treatment and Diagnosis.

2. Itemised accounts giving a breakdown and description of costs claimed, together with receipts if any accounts have been paid by you.

*** Failure to provide these documents may result in delays in processing your claim.**

Type of Injury or Sickness	Date of Accident or Commencement of Sickness / /
If ***injury*** – Give full details of Accident	
Date of First Medical/Dental Consultation / /	Name of Doctor, Dentist and/or Hospital
Details of other treatment by Doctor, Dentist and/or Hospital	
Dates in Hospital – Admitted / / am/pm	Discharged / / am/pm
Did you contact our Emergency Assistance department? ☐ **Yes** ☐ **No**	
Name and Address of usual family doctor	

If claiming for more than one event, please list separately and clearly detail what receipt/expenses relate to which event and if initial treatment or follow up appointment. Please label each receipt accordingly. If you need more room please attach a supplementary sheet to this form. Claims will be converted to New Zealand dollars using the currency rate applicable at the date and time the expenses were incurred.

Claim	Name of Doctor/Dentist/ Pharmacy/Hospital or Provider	Conditions/symptoms treated or procedure performed	Date of Treatment	Amount Charged (State Currency)	Paid Yes/No and receipt attached	Indicate if initial treatment/ consultation or follow up
A	e.g. Doctor R Smith	e.g. Sinus Infection	e.g. 10/02/16	e.g. EUR 100	e.g. Yes	Follow up

Section B. Cancellation Charges / Loss of Deposit Claim / Additional Expenses
THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Copy of original Itinerary.
2. Letter from Travel Agent or, where travel was not arranged through a Travel Agent, a letter from the relevant organisation through whom travel was booked, confirming payments made, refunds given and any amounts you are out of pocket.
3. Proof of payment for trip (ie. receipts, credit card/bank statements showing payments made).
4. If travel was cancelled due to Medical Reasons/Death – please provide a medical certificate or a copy of Death Certificate (if applicable).
5. If travel was cancelled by a Transport Provider – letter from them explaining the circumstances of the cancellation and any refund/ compensation paid or payable to you.

What was the reason why you could not commence or complete your proposed Journey?

Was your Journey cancelled as a result of Injury/Sickness to any other person? ☐ **Yes** ☐ **No**

If ***Yes***, please provide	
Full Name	Date of Birth / /
Address	Relationship
Nature of Injury/Sickness	
Date your Journey was booked: / /	Date your Journey was cancelled / /

Details of Journey

Date	Description of Booking	Supplier	Amount Paid	Refund Received	Amount Claimed

Please state the reason/event that caused the additional expenses being incurred

What was the unexpected expense incurred?

Please list each receipt/bill separately in the table below. Claims will be converted to New Zealand dollars using the currency rate applicable at the date and time the expenses were incurred.

Date of Expense	Description of Expense	Amount	Date of Original Plan	Description of Original Cost	Amount
e.g. 24/07/07	e.g. Hotel in Paris	e.g. EUR 100	e.g. 24/07/07	Flight to Munich	e.g. EUR 75

Section C. Luggage / Personal Effects / Delayed Luggage Claim
THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM*

1. Proof of ownership of the items claimed (ie. tax invoices, receipts, or credit card/bank statements proving purchase of the item/s).

2. Report made to the Transport Provider/ Police/Hotel or other appropriate Authority.

Give full details of how losses, damage or thefts occurred: (Detail each event)

Date loss/damage occurred / /	Time am/pm	Location/Country
Date loss/damage reported / /	Time am/pm	Location/Country
Loss/damage reported to – (Police, Airline or other Authority) Name		
Were items lost/damaged by Carrier? (e.g. Airline) ☐ **Yes** ☐ **No**	Name	

Have you lodged a claim or complaint against any Carrier/Airline or other Authority or against any individual responsible for the loss or damage to your property? If ***Yes***, please provide details in the table below and attach copies of correspondence. If ***No***, you should proceed to claim with your Carrier/Airline before submitting your claim to Allianz Global Assistance.

NOTE: The 1999 Montreal Convention imposes a liability upon Airlines and you should claim from them first.

Carrier	**Claim no.**

What action was taken to recover lost items?

Are any of the items covered by other insurance? ☐ **Yes** ☐ **No**	
If ***Yes*** – Which company	Policy Number
Were all the missing articles owned by you? ☐ **Yes** ☐ **No**	
If not, give details	

Full Details of Articles Claimed	**Store Purchased**	**Country Purchased**	**Original Date of Purchase**	**Original Purchase Price**	**Amount Claimed (NZD)**	**Proof of Purchase Attached?**

Section D. Rental Vehicle Excess Claim
THE FOLLOWING ITEMS MUST BE INCLUDED WITH THIS CLAIM

1. Copy of your Rental Vehicle Agreement.
2. Copy of the Repair Invoice if claim is due to the Rental Vehicle being damaged.
3. Copy of documents showing amount debited to you by Rental Vehicle company for damage/excess.
4. Report made to the Police or other appropriate Authority.

Date and time of accident/incident / /	Location of accident/incident
Rental Vehicle company name	Country where the vehicle was rented:

Please state in full, exactly what happened for the claim to arise (if necessary, a diagram may be used to depict the event):

Was the damage due to a collision with another vehicle? ☐ **Yes** ☐ **No**

Did police attend the incident? ☐ **Yes** ☐ **No**	Was the accident/incident your fault? ☐ **Yes** ☐ **No**
Repair costs	Date the damage was paid for / /
Excess you were liable to pay	Amount you are claiming for
Have you received compensation from any person or party involved in the accident or incident: ☐ **Yes** ☐ **No**	
If Yes, please state the amount received	

Section E. Other
THE FOLLOWING DOCUMENTS MUST BE INCLUDED WITH THIS CLAIM

Please tell us in as much detail as possible what happened to you in order for you to make this claim. Be as specific as possible, including dates and amounts paid. If there is not enough room in the space provided, you may continue your description of the events on a separate piece of paper.

Payment Details

Provide your bank details below for a direct credit to your nominated bank account.
Please note we cannot deposit into a credit card account.
If we are required to make a payment on your behalf no payment will be made until we receive payment, from you, of any applicable excess.

Name of Bank	
Branch:	Account Holder

Bank			Branch					Account number								Suffix			

Medical Authority and Declaration

I DECLARE THAT:

- I will use my best endeavours and render all reasonable assistance and co-operation to Allianz Global Assistance in the assessment of my claim;
- The information supplied by me is true and correct and I have not withheld any information likely to affect the assessment of my claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proof of my claim, Allianz Global Assistance has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy;
- A photocopy of this Authorisation shall be considered as effective and valid as the original and I specifically authorise its use as such.

I appoint Allianz Global Assistance to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I authorise any person, insurer, corporation, institution, private or government organisation, whether named by me or not, to provide such information as Allianz Global Assistance in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);
- my Health Insurance claims history;
- any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

Signature of Claimant	Date / /
Name of Claimant	

Signature of Witness	Date / /
Name of Witness	