Corporate Travel
Claim Form
2024 02

Important: Please read before you complete this form

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. Please note that Sections 1, 2, 3, 4, 5 & 12 are COMPULSORY.
3. Note: This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by Batch Underwriting.

Batch
Accident & Health

01. POLICY AND PERSONAL INFORMATION

ALL QUESTIONS REQUIRE COMPLETION

POLICY NUMBER

EXPIRY DATE

MEMBER NUMBER (IF APPLICABLE)

NAME OF INSURANCE BROKER (IF KNOWN)

NAME OF INSURED COMPANY

YOUR POSITION

☐ CEO/COO ☐ Director ☐ Employee ☐ Spouse ☐ Dependent Child ☐ Other

TITLE

GIVEN NAME(S)

☐ M ☐ F ☐ Other

FAMILY NAME

DATE OF BIRTH

RESIDENTIAL ADDRESS (CANNOT BE A PO BOX)

SUBURB

STATE

POSTCODE

EMAIL ADDRESS

DAYTIME CONTACT NUMBER

ALTERNATIVE NUMBER

Are you able to claim through any other source? Yes ☐ No ☐

If Yes, please provide details

Have you made previous travel insurance claims? Yes ☐ No ☐

If Yes, please provide details

02. PAYMENT DETAILS

COMPULSORY

Please provide bank and account details for payment

ACCOUNT HOLDERS NAME

BSB NUMBER (6 DIGITS)

ACCOUNT NUMBER

BANK

(Alternatively supply a deposit slip noting the following information)

03. GST DECLARATION

Are you registered for GST Purposes? Yes ☐ No ☐

If Yes, What is your ABN?

Must be completed only in respect of:

- Each company owned item
- Any other expenses where Australian GST is incurred by the company.

Have you ever claimed, or are you entitled to claim an Input Tax Credit (ITC) in respect to GST paid on the insurance policy under which this claim is being made? Yes ☐ No ☐

If Yes, what percentage of ITC did you claim or are you entitled to claim? %

04. TRAVEL INFORMATION

COMPULSORY

DEPARTURE DATE

RETURN DATE

DEPARTURE CITY

DESTINATION CITY

DEPARTURE COUNTRY

DESTINATION COUNTRY

REASON FOR TRAVEL

☐ Business/Work ☐ Holiday ☐ Combination ☐ Other

05. DETAILS OF INCIDENT

COMPULSORY

DATE OF INCIDENT

TIME

AM/PM

INCIDENT CITY

INCIDENT COUNTRY

Please describe how the accident / damage / theft / loss / illness occurred and complete relevant sections

06. MEDICAL EXPENSES

IF APPLICABLE

- This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.
- Medical Receipts will be required to accompany this section.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the curtailment of the journey.
- All medical and hospital accounts Incurred within Australia must first be submitted to Medicare for refund, also to your private health fund if applicable.

Was the Emergency Assistance Company contacted? Yes ☐ No ☐

If an illness, has the claimant suffered this complaint before? Yes ☐ No ☐

If Yes, please provide details

Date of Expense	Medical and/or Hospital Expenses (use separate sheet if insufficient space)	Amount Claimed (Please state currency)

07. LOST, STOLEN OR DAMAGED LUGGAGE & PERSONAL EFFECTS

IF APPLICABLE

- In the event of loss or damage occurring whilst in the care of carriers (airlines, bus companies, etc) the carrier should have been notified and a Property Irregularity Report obtained and forwarded with this form.
- Full description of articles lost or damaged with details of the nature of damage, full particulars of purchase price and date and place of purchase are to be entered on the statement of claim below, together with proof of lost or damaged goods (e.g. Receipts, Valuation, Certificates, Credit Card Statements).
- You should obtain an estimate for repairs where feasible or written confirmation from a competent repairer or dealer that the articles are damaged beyond economic repair.
- All optical expenses must first be submitted to your health fund, if applicable.
- Lost/Stolen goods should be reported to the Police.

Was the incident reported to Police or any other authority? Yes ☐ No ☐

If Yes, please provide report / Incident No.

If No, please provide explanation:

Were articles lost by a carrier? Yes ☐ No ☐

Note: The Warsaw Convention & The Montreal Conventions imposes a liability upon the carrier and you should claim against them first.

Were all the missing articles your property? Yes ☐ No ☐

If No, Who is the owner?

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? Yes ☐ No ☐

If Yes, please provide details and attach correspondence:

If No, please provide explanation:

If you are claiming for spectacles, dentures, or a hearing aid, are these items claimable against your private health fund? Yes ☐ No ☐

NAME OF FUND

MEMBERSHIP NUMBER

AMOUNT PAID BY HEALTH INSURER

CURRENCY

08. DELAYED BAGGAGE

IF APPLICABLE

DATE OF YOUR ARRIVAL

TIME

AM/PM

COMPENSATION PAID BY CARRIER

CURRENCY

DATE OF LUGGAGE ARRIVAL

TIME

AM/PM

STATEMENT OF CLAIM

Attach separate sheet if insufficient room. Give a full description of the article(s) lost or damaged and in addition a fully detailed description of the damage where applicable. Please attach relevant documentation to support your claim, e.g. receipts, photographs, manuals.

Full description of article/s & details of damage where applicable (provide evidence)	Original Cost Price	Date and Place of Purchase	Has item been replaced	ITC%	Amount Claimed	Currency
e.g Dell Latitude x150 - Cracked Monitor – photo #1	*$2,600 AUD*	*26/08/2021 - Dell website*	*No*	*65%*	*$2,600*	*AUD*

09. ADDITIONAL CANCELLATION/CURTAILMENT/INTERRUPTION EXPENSES

IF APPLICABLE

- This section is to be completed ONLY where the event has occurred AFTER THE COMMENCEMENT of the Insured Travel.
- Only original accounts or receipts for accommodation and transport costs will be accepted.
- For additional expenses, a MEDICAL CERTIFICATE, or the Medical Certificate on Page 7 of this form, from the doctor who treated you must be provided to support change of plans due to accident, illness or death.

If you are claiming for additional expenses, what were your original plans for accommodation / transport and how were they changed? Please ensure copies of original and amended itineraries are provided.

Date of Expense	Additional Transport / Accommodation Expenses (Please supply Full Details)	Amount Claimed	Currency

Date of Expense	Forfeited Expenses (Please supply Full Details)	Amount Claimed	Currency

10. HIRE CAR EXPENSES

IF APPLICABLE

Please ensure a copy of your Hire Vehicle Agreement, Damage Report and repair invoice(s) are attached.

☐ Car ☐ Other

NAME OF VEHICLE HIRE COMPANY

TITLE

DRIVER'S FULL DETAILS

RENTAL VEHICLE EXCESS	CURRENCY	ACTUAL REPAIR COSTS	CURRENCY	AMOUNT YOU ARE CLAIMING	CURRENCY
$		$		$	

11. CANCELLATION / LOSS OF DEPOSITS

IF APPLICABLE

- If you are claiming because you cancelled your trip PRIOR to departure, as a result of injury, illness or death, you MUST have the Medical Certificate on Page 7 completed by the regular doctor of the person whose state of health has resulted in the claim.
- We reserve the right to call for all details of medical history of the claimant, or the person whose accident, illness or death necessitates the cancellation of the journey.
- A supporting document from the travel provider showing cancellation charges must be submitted with this form.

DATE TRAVEL ARRANGEMENTS BOOKED:

DATE OF CANCELLATION:

REASON FOR CANCELLATION:

If cancellation is due to accident, illness or death state the name of the person whose accident, illness or death necessitates the cancellation of the travel. IN THE EVENT OF DEATH, PLEASE ATTACH DEATH CERTIFICATE

TITLE

GIVEN NAME(S)

FAMILY NAME

RELATIONSHIP OF PERSON TO CLAIMANT

AMOUNT PAID $

CURRENCY

AMOUNT REFUNDED $

CURRENCY

AMOUNT CLAIMING $

CURRENCY

If no refund amount is noted please state why (you must obtain all refund possible)

12. DECLARATION

COMPULSORY

I/We declare that to the best of my knowledge and belief, the information provided on this claim form and in any attached documentation is true and correct and that I/We have not withheld any relevant information.

I/We consent to Proclaim and/or its agent using the personal information I/We have provided for the purpose of processing my claim.

I/We understand that if I/We choose not to provide the required details, this is my/our choice; however, Proclaim and/or its agent may not be able to process my/our claim.

I/We consent to Proclaim and/or its agent disclosing my/our personal information to other insurers, an insurance reference service, claims adjusters, lawyers and other consultants or as required by law.

I/We also consent to Proclaim and/or its agent disclosing my/our personal information to and/or collecting additional information about me/us, from investigators or legal advisors.

I/We also consent to Proclaim and/or its agent to authorise any hospital and/or physician who has treated me to provide Batch Underwriting with copies of medical records or of my past medical history, as requested.

I/We acknowledge that I/We have read and understood the Privacy Statement found at www.batchunderwriting.com and consent to the collection, storage, use and disclosure of personal and sensitive information to all persons affected by this claim.

I/We acknowledge that if I/We do not agree to the collection of this personal information then Proclaim and/or its agent will be unable to process my/our claim.

SIGNATURE OF CLAIMANT

DATE

SIGNATURE OF THE INSURED (if other than claimant)

DATE

13. MEDICAL CERTIFICATE

This section must be fully completed by attending doctor - any fee for completion of this section is the responsibility of the insured person

COMPULSORY

TITLE | GIVEN NAME(S)

☐ M ☐ F ☐ Other

FAMILY NAME

DATE OF BIRTH

1. Are you his/her usual medical attendant? Yes ☐ No ☐

2. If Yes, for how long? ☐☐ DAYS ☐☐ MONTHS ☐☐ YEARS

3. Please give precise details of the nature of the illness or injury.

4. Date of onset of illness, or date of injury.

5. Date on which you were first consulted in relation to the condition described above and, in your opinion, how long the condition has been present prior to consultation.

First Consultation Date

Condition has been present prior to consultation for:

6. Are you prepared to certify that solely due to the condition described in question 3, the claimants was/were compelled to cancel the travel arrangements? Yes ☐ No ☐

7. What treatment, if any, has your patient previously received for this or any other related condition, and when was treatment received?.

8. Is he/she suffering from any chronic disease or illness or from any physical defect or infirmity?

9. If the claim is as a result of a death, in your opinion, was it sudden and unexpected? Please give reasons for your answer.

PRINT NAME | QUALIFICATION | SIGNATURE

ADDRESS

PHONE | EMAIL | DATE