Ticket insurance claim form

How do I make a claim?

You can make your claim in 3 simple steps

1 Fill out this claim form

Please complete Parts 1 and 2a-d of this claim form.

2 Provide all relevant documentation

THE FOLLOWING DOCUMENTS NEED TO BE SENT TO US WITH YOUR CLAIM

1. A copy of your Certificate of Insurance
2. Your original unused ticket (or barcode if it is an electronic ticket)
3. Supporting documentation. See part 2d for help.

Failure to provide all necessary evidence and details may result in delays processing your claim.

3 Send us your claim

@	**claims@covermore.co.nz** (you can send up to 10 MB of attachments)
✉	**Cover-More Claims Department, PO Box 105 - 203 Auckland 1143** (registered or express post recommended)

What happens next?

- If you email your claim, you will receive a receipt confirmation by email with your claim number. Our response to your claim will follow within 10 working days.
- If you post your claim, we will contact you with our response to your claim within 10 workding days of us receiving your documents.

Claim form

Part 1: General information - All questions in this section must be answered

Your policy number

Unsure? Contact your policy provider to obtain a copy of the Certificate of Insurance.

a. Your information

Title | Given name(s) | Surname | Date of birth

Occupation | Mobile phone (or best other contact) | Email address

Postal address | Suburb | City | Postcode

b. Payment

If your claim is approved we will deposit your settlement into your nominated bank account below (we cannot make payments to a credit card). We prefer to pay successful claims directly into your bank account as it is faster and safer.

Name of bank | Branch

Account holder name | Account number

If you are a non-New Zealand resident, please note that in order to provide payment via bank transfer we will require the name of your bank, the account name, the International Bank Account Number (IBAN) and the Bank Identification Code (BIC) or SWIFT code.

c. IRD number holders

Are you registered for GST purposes? ☐ Yes ☐ No

Have you claimed or are you entitled to claim GST paid on the insurance policy under which this claim is being made? ☐ Yes ☐ No

d. Your declaration

I/we declare that:

- all statements and particulars stated on this form and all documents submitted are true and correct.
- I/we will cooperate fully with the insurers in the assessment of my claim.
- I/we have not withheld any material information connected with this claim that will inhibit the insurer's ability to make a fair and reasonable assessment of my claim.
- I/we acknowledge that my personal information may be disclosed to, and obtained from, certain other parties including the Insurance Reference Services database, other insurers and government agencies.
- I/we assign to the insurer all rights of recovery/salvage against any person or organisation and will cooperate to secure such rights.
- you may send the personal information included on this form and related documents overseas to assess investigate and pay my claim. I understand that this information may not be subject to the same level of privacy as is offered by the New Zealand Privacy Regime and that I will not be able to seek redress under the Privacy Act 1993 in the overseas jurisdiction.
- where I/we provide information, including sensitive information, about other individuals, that I/we have informed them (or their parent, guardian, executor or Power of Attorney) of the personal information being provided and the contents of the Privacy Notice and have obtained their consent to providing the information.

Signature of claimant(s)

Date

WARNING: We are committed to investigating claims to avoid passing the costs of dishonest and fraudulent claims on to you. We try to conduct investigations quickly and with minimal disruption. Fraud will be reported to the police.

Part 2a: Claim Information

Date of event **Time of event**

__ __ / __ __ / __ __ AM/PM

Name of event

Place of event

Date on which you were aware that you/your companion would not be able to attend the event

Please provide an explanation of your claim and why you and/or your companion were unable to attend the event (Please include a letter if more space is required).

If the claim was caused by a health condition/dental problem/death please answer the following questions:

Person whose state of health/death caused the claim

Given name(s)

Surname

Relationship of that person to you

Has the illness/injury occurred before? ☐ Yes ☐ No If Yes, advise the condition.

Were you/was the person treated as a hospital inpatient?

☐ Yes ☐ No

Date admitted **Time admitted**

__ __ / __ __ / __ __ AM/PM

Date discharged **Time discharged**

__ __ / __ __ / __ __ AM/PM

2b: Ticket and payment details

Number of tickets

Total amount claimed*

Ticket cost per ticket*

Amount of refund received

*Ticket cost excluding any service or delivery fee

Please answer all questions relating to what is being claimed, otherwise we will be unable to process your claim.

2c: Details of companion(s)

Insert details of companion(s)/intended recipients of ticket(s) if any claim is made for unused ticket(s) you purchased for someone else. If there is not enough room in the space provided, please continue details of companions on a separate piece of paper.

Name of companion

Address

Name of companion

Address

2d: Reason for claim for payment of ticket cost (PLEASE TICK APPROPRIATE BOX)

		supporting documents required
☐	Injury or sickness of you or your companion	The Medical Certificate (pages 5 - 6) completed by your usual medical practitioner
☐	Injury or sickness of a relative	The Medical Certificate (pages 5 - 6) completed by your usual medical practitioner
☐	Death of you or your companion	The Death Certificate and the Medical Certificate (pages 5 - 6) completed by your usual medical practitioner
☐	Death of a relative	The Medical Certificate (pages 5 - 6) completed by your usual medical practitioner and the Death Certificate
☐	Transport accident causing bodily injury	A report from the police/official body and the completed medical certificate from the doctor or dentist
☐	Vehicle breakdown within 48 hours prior to the event	A letter or report from the repair service or public transport provider
☐	Transport cancellation/delay/shortening/diversion because of strike, riot, hijack, civil protest, weather or natural disaster	A letter or report from the transport provider
☐	Home/place of business rendered uninhabitable by fire, explosion, weather, natural disaster, burglary or vandalism	A letter or report from the police, fire brigade or household/business insurer
☐	Assault causing bodily injury	A police report and the Medical Certificate (pages 5 - 6) completed by your usual medical practitioner
☐	Jury duty	A letter from the Court
☐	Military orders	A letter from your Commanding Officer
☐	Redundancy from full-time employment	A letter from your employer
☐	Work relocation more than 100 km from usual place of work	A letter from your employer

We reserve the right to request other documentation be submitted in order to substantiate your claim.

Please note that in addition to the above documents, we will require your original unused ticket (or barcode if it is an electronic ticket), regardless of the reason for the claim.

Medical form (Page 1 of 2)

Submit your claim to Cover-More by: **Post** Cover-More Claims Department, PO Box 105 - 203, Auckland 1143
Fax (09) 300 7371 **Email** claims@covermore.co.nz

Medical Authority (To be completed by the person who was ill/injured)

To be completed by the person whose state of health caused the claim (or their Parent/Guardian, Executor of the Estate or Power of Attorney if applicable). Details of the patient's usual doctor (of at least 12 months prior to the policy issue date).

I authorise the insurer or its representatives to obtain from any person or organisation any information in respect of treatment for the medical/dental condition(s)/injury(ies) or death which resulted in this claim. I acknowledge that a photocopy/scanned copy of this authorisation shall be considered as valid as the original.

Signature of patient/Executor/Power of Attorney

Patient's name

Date of birth ☐☐/☐☐/☐☐

Signed date ☐☐/☐☐/☐☐

Name of usual doctor or dentist in New Zealand

Relationship to patient (if applicable)

Doctor's or dentist's phone number

Doctor's or dentist's fax number

Doctor's or dentist's email or postal address (include postcode)

Medical Certificate (To be completed by the patient's usual doctor)

To be obtained at the claimant's own expense from the patient's usual medical practitioner (whom they have been attending for at least 12 months prior to the issue date of the policy). Required for all claims arising from a person's health/medical condition, death or dental condition. If you do not have a usual medical practitioner, please contact us.

IMPORTANT: The medical practitioner is respectfully requested to give as much detail as possible when answering these questions in order to assist our client with their claim and avoid the necessity of additional questions. PLEASE USE BLOCK LETTERS. You may reply in letter format however answers to each of the questions below that are relevant to your patient or the claim being made by the claimant will need to be included.

PLEASE INCLUDE ALL PATIENT DISCHARGE SUMMARIES

1. Name of patient

2. Date of birth ☐☐/☐☐/☐☐

3. Are you the patient's usual G.P.? ☐ Yes ☐ No

a. If Yes, for how long?

b. If No, do you have access to their medical records? ☐ Yes ☐ No
From what date? ☐☐/☐☐/☐☐

4. Please give a precise diagnosis of the illness or injury or cause of death that has given rise to the claim. If an injury, how was it sustained?

5. On what date did the patient first consult You in relation to this condition or symptoms of this condition? ☐☐/☐☐/☐☐

6. Have you or anyone else known to you previously treated or advised this patient in respect of the same/similar/related illness or injury as described in the answer to question 4? ☐ Yes ☐ No

7. Prior to the policy issue date, was the patient receiving any regular advice, treatment or medication or being investigated for this condition or any similar/related condition? ☐ Yes ☐ No If Yes, please give details and please provide details and include copies of all letters from referred specialists, the patient's full medical history, current medications and all hospital visits for the past 2 years.

The claimant must indicate (by ticking the relevant box) which is applicable, question 8 or 9.

8. Inability to attend event because of injury of sickness of policy holder or companion
   (a) Did you recommend that the patient not attend the Event due to the patient's state of health? ☐ Yes ☐ No
   (b) On what date did you make this recommendation? ☐☐/☐☐/☐☐

9. Inability to atttend event because of injury, sickness or death of a relative
   (a) Did you recommend that the patient not attend the event due to the patient's state of health? ☐ Yes ☐ No
   (b) On what date did you make this recommendation? ☐☐/☐☐/☐☐

Medical Certificate (page 2 of 2)

10. Please provide the following dates, where applicable.

a. Date of onset of illness/injury/death and/or date of deterioration/exacerbation

☐☐/☐☐/☐☐

b. Date tests prescribed

☐☐/☐☐/☐☐

c. Date tests carried out

☐☐/☐☐/☐☐

d. Date results advised to the patient

☐☐/☐☐/☐☐

e. Date referred to specialist/surgeon

☐☐/☐☐/☐☐

f. Date of death

☐☐/☐☐/☐☐

g. Name and address of specialist/surgeon

11. Date the patient was advised that they would not be able to attend the event.

☐☐/☐☐/☐☐

12. If due to pregnancy:

a. On what date was the pregnancy confirmed?

☐☐/☐☐/☐☐

b. How many weeks pregnant was the person on this date?

c. Was the conception medically assisted? ☐ Yes ☐ No

d. Have there been previous complications with this or any other pregnancy? ☐ Yes ☐ No

13. Was the patient on a waiting list for hospital? ☐ Yes ☐ No If Yes, please give details.

14. Was the patient hospitalised?

☐ Yes ☐ No

If Yes, please provide admission date ☐☐/☐☐/☐☐

I certify that I have examined the patient named above and/or have referred to their medical records and confirm that the information given in this Medical Certificate is a true and correct statement.

Doctor's signature

Name

Date ☐☐/☐☐/☐☐

Qualification

Telephone

Email address, fax number or postal address