

CLAIM FORM

# Credit Card Travel Insurance

**Important Notice**

- Please complete this form digitally if possible. You may also print and use a dark pen to complete, writing in block letters.
- Please email your completed form and supporting documents to [NZTravelClaims@aig.com](mailto:NZTravelClaims@aig.com), or post to Travel Claims, AIG Insurance New Zealand Limited, PO Box 1745 Shortland Street, Auckland 1140. Please keep a copy for your records.
- Please read this form carefully. Please complete section A (your details) and section I (declaration) and each section that you are claiming under.
- To show that you have met the eligibility requirements for cover under this policy, you will need to provide confirmed flight itineraries or other travel bookings and a copy of your credit card and/or bank statements showing pre-paid travel expenses.
- Further evidence required to support your claim is detailed under the relevant sections. Please provide this with your claim form to avoid delays in assessing your claim. We may require more information during the process so please include any other information you think may be relevant when you submit your claim.
- We reserve the right to request original receipts, reports or other documentation to substantiate your claim.
- Please provide supporting documents in English where possible. Where this is not possible, please note that we may require additional time to translate and review documents, which could delay claim processing.
- If you incurred expenses in a foreign currency please note the currency in the amount claimed under the relevant section. We will convert any amounts incurred in foreign currencies to New Zealand dollars using the rate of exchange current at the date and time the expense was incurred.
- If you, or any person included in your claim, provide any information, in support of your claim which is false or deliberately misleading, AIG reserves the right to decline your claim in part or in full.

**Sections to be Claimed Under**

Please tick the applicable box(es) to show which section(s) of the policy you are claiming under. Sections A and I must be completed in all cases for us to assess your claim.

<input type="checkbox"/> Section A	Your details (must be completed)	<input type="checkbox"/> Section F	Delayed luggage
<input type="checkbox"/> Section B	Overseas medical, hospital and dental expenses	<input type="checkbox"/> Section G	Rental vehicle excess
<input type="checkbox"/> Section C	Cancellation charges/loss of deposits	<input type="checkbox"/> Section H	Other
<input type="checkbox"/> Section D	Additional expenses	<input type="checkbox"/> Section I	Declaration (must be completed)
<input type="checkbox"/> Section E	Luggage and personal effects		

**Payment**

AIG requires the following payment details, should your claim be accepted. Payment is a direct credit to a New Zealand bank account. Please complete bank details and account number below:

Bank Number	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
Bank	<input type="text"/>			
Account Name	<input type="text"/>		Email (Payee)	<input type="text"/>

I agree the above bank details belong to the named payee

## Section A. Your Details

### Details of Policy Holder

A1 Who is the Card Account Holder?	First Name			
	Surname			
A2 What are the first six details of your credit card this policy relates to?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
A3 Who is the issuing bank?				
A4 What type of card is it (e.g. Gold, Platinum, Airpoints Platinum)?	Merchant (e.g. Visa)			
	Card type (e.g. Gold)			
A5 How much of your pre-paid travel costs were charged to this card? If nil state 'nil'.				
A6 What date did you charge your first pre-paid travel expenses to your card?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
A7 What was your scheduled travel departure date?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
A8 What was your scheduled travel return date?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>			
A9 Did you purchase any optional policy extensions? eg. pre-existing medical condition cover, duration extension cover If yes, please go to A10, otherwise go to A11.			<input type="checkbox"/> Yes <input type="checkbox"/> No	
A10 What is the Acceptance Number for the optional extension?				

### Details of Person Claiming Under Policy

A11 What is your name?	First Name			Surname	
A12 What is your date of birth?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>				
A13 What is your address?					
A14 What are your contact details?	Mobile			Home	
	Work			Email	
A15 Have you lodged a claim under any other insurance policy, medical or health scheme or Act of Parliament (including ACC) that may also cover your loss? If yes, please complete A16.					<input type="checkbox"/> Yes <input type="checkbox"/> No

A16 Please provide further details of your claim, including who the claim was against, and the outcome of the claim.

## Section B. Overseas Medical, Hospital or Dental Expenses

Complete this section if you have incurred medical expenses resulting from an injury or sickness, or if you were hospitalised, or if you suffered a dental injury whilst you were overseas. You will also need to complete section C and/or section D of this form if you had to come home early or incur additional expenses due to your injury, sickness or hospitalisation.

### Claims evidence we require under this section

Medical reports detailing the injury or sickness and any treatment you had.

If you were hospitalised, your discharge summary.

Bills or receipts for any costs you are claiming for.

B1 What happened to give rise to your claim for injury or sickness?

B2 Where were you when you suffered injury or sickness?

Location

Country

B3 Have you ever suffered from the same or similar injury or sickness in the past?

Yes  No

If you selected 'yes' please go to B4, otherwise go to B5.

B4 What previous injury or sickness did you suffer?

Detail of injury or sickness suffered in the past	Date of diagnosis	Date you last sought medical attention for this condition	Are you on regular medications for this condition?	Have you had a preexisting approval for this condition?
	D D M M Y Y	D D M M Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	D D M M Y Y	D D M M Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	D D M M Y Y	D D M M Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	D D M M Y Y	D D M M Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	D D M M Y Y	D D M M Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
	D D M M Y Y	D D M M Y Y	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

B5 Who is your usual doctor in New Zealand?

Name / Practice

Address

Phone number

Email

B6 When did the injury happen, or for sickness when did symptoms first appear?	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

B7 When did you first seek medical or dental attention for the injury or sickness?	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

B8 Who did you seek medical attention from?	Name/Practice			
	Address			
	Phone number		Email	

B9 Were you hospitalised overseas following the injury or sickness?  Yes  No

If you selected 'yes' please go to B10, otherwise go to B14.

B10 Where were you hospitalised?	Hospital name			
	Address			
	Phone number		Email	

B11 When were you admitted to hospital?	Time		<input type="checkbox"/> AM	<input type="checkbox"/> PM					
	Date	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

B12 When were you discharged from hospital?	Time		<input type="checkbox"/> AM	<input type="checkbox"/> PM					
	Date	<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

B13 Did you contact AIG assistance to advise of your hospitalisation?  Yes  No

B14 What costs are you claiming for? Please list each receipt/bill separately. Claims will be converted to New Zealand dollars using the currency rate applicable at the date and time the expenses were incurred.

Name of treatment provider	Location	Treatment provided	Date of treatment	Amount claimed	Have you paid for this treatment?						
			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y						
			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y						
			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y						
			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y						
			<table border="1" style="width:100%; border-collapse: collapse;"> <tr> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">D</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">M</td> <td style="width:12.5%; text-align: center;">Y</td> <td style="width:12.5%; text-align: center;">Y</td> </tr> </table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y						
<b>Total:</b>				\$							

### Section C. Cancellation Charges/Loss of Deposits

Complete this section if you have incurred out of pocket expenses for non-refundable travel deposits paid in advance by you, resulting from cancellation or curtailment of all or part of your travel itinerary. You will also need to complete section D of this form if you incurred additional expenses as a result of the same event which required you to cancel or curtail your journey. Please note that any credits you have received may not be considered a Loss of Deposit.

#### Claims evidence we require under this section

- Your original itinerary including terms and conditions issued by the relevant travel or accommodation providers.
- Proof of your payment for pre-paid expenses.
- A statement or letter from your travel or accommodation providers showing the date they were advised of the cancellation and any refunds given.
- If travel was cancelled by a travel or accommodation provider - letter from them explaining the circumstances of the cancellation and any refund/compensation paid or payable to you.
- A death certificate if additional expenses were incurred due to a death or a medical certificate if additional expenses were incurred due to a medical event.

C1 What best describes your need to cancel your journey?

- An injury or sickness happening to you. Go to C7.
- A death, injury or sickness of another person. Go to C2.
- Another event outside your control. Go to C7.

C2 What is the other person's full name?	First Name									
	Surname									
C3 What is their date of birth?	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>		D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y			
C4 What is their address?										
C5 What is their relationship to you?										

C6 Had this person ever suffered from the same or similar injury or sickness in the past?  Yes  No

C7 What was the date of the event that led to the cancellation of your journey?	<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	Y	Y
D	D	M	M	Y	Y	Y	Y		

C8 What happened that led to cancellation of your journey?

C9 What deposits you are claiming? Please provide figures in NZ dollars.

Pre-paid expense item	Name of travel or accommodation provider	Date deposit was booked/paid	Date you advised provider of cancellation	Amount Paid (A)	Refund due or received (B)	Amount Claimed (Equals A-B)
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	\$
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	\$
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	\$
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	\$
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	\$
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	\$
<b>Totals:</b>				\$	\$	\$

C10 If you have not applied for refunds against all of your travel providers, please explain why:

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## Section D. Additional Expenses

Complete this section if you incurred expenses during your journey as a result of an event outside your control that were over and above costs which you had expected to pay as part of your original travel itinerary. Note that expected costs include meals that you would have paid for in any case, had the reason for your claim not occurred.

### Claims evidence we require under this section

- Your original itinerary.
- Proof of your payment for pre-paid expenses.
- Receipts for your payment of additional expenses.
- If additional expenses were incurred due to something to do with a travel or accommodation provider – letter from them explaining the circumstances of the event and any compensation paid to you.
- A death certificate if additional expenses were incurred due to a death or a medical certificate if additional expenses were incurred due to a medical event.

D1 Are you also claiming under the cancellation benefit for the same event which led to you incurring additional expenses?  Yes  No

If you selected 'yes' please go to D8, otherwise go to D2.

D2 What best describes your need to incur additional expenses?

- An injury or sickness happening to you. Go to D8.
- A death, injury or sickness of another person. Go to D3.
- Another event outside your control. Go to D8.

D3 What is the other person's full name?	First Name	
	Surname	

D4 What is their date of birth?

D5 What is their address?

D6 What is their relationship to you?

D7 Had this person ever suffered from the same or similar injury or sickness in the past?  Yes  No

D8 What was the date of the event that led to you incurring additional expenses?

D9 What happened that led to you incurring additional expenses?

D10 Have you received compensation or a refund from any other party as result of the event?

Yes  No

If you selected 'yes' please go to D11 otherwise go to D12.

D11 What compensation or refund did you receive?

D12 Were you required to return to New Zealand following this event?

Yes  No

If you selected 'yes' please go to D13, otherwise go to D14.

D13 When did you return to New Zealand?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

D14 Did you hold a return travel ticket for your journey before you left New Zealand?

Yes  No

D15 What additional expenses did you incur?

Description of expense	Name of carrier/ provider	Date the expense was incurred	Amount incurred	Was the expense budgeted in original itinerary?						
		<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y					
		<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y					
		<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y					
		<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y					
		<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y					
		<table border="1"><tr><td>D</td><td>D</td><td>M</td><td>M</td><td>Y</td><td>Y</td></tr></table>	D	D	M	M	Y	Y	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
D	D	M	M	Y	Y					
<b>Total:</b>			\$							



### Section E. Luggage and Personal Effects

Complete this section if your accompanied baggage items were lost or damaged overseas. Please note that if you are also claiming for delayed baggage under Section F, we will reduce the amount that we pay for your claim under this section by the amount that we agree for your claim in Section F.

#### Claims evidence we require under this section

Proof of ownership and value for the items being claimed.

A police report, property irregularity report or a report from the transport provider, hotel or appropriate authority explaining your loss.

E1 How did the loss or damage occur? (detail each event)

E2 When did the loss or damage occur?	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

E3 Where did the loss or damage occur?	<input type="text"/>
	<input type="text"/>

E4 Were you with the items when the loss or damage occurred?  Yes  No

E5 When did you become aware of the loss or damage?	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

E6 Where were you when you became aware of the loss or damage?	<input type="text"/>
	<input type="text"/>

E7 When did you report the loss or damage?	Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
	Date	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

E8 Who did you report the loss or damage to?	<input type="text"/>
	<input type="text"/>

E9 What action was taken to recover lost items?

<input type="text"/>
<input type="text"/>

E10 Were the lost or damaged items owned by you?

Yes  No

If you selected 'no' please go to E11, otherwise go to E12.

E11 Who owns the items?

E12 Were the items lost or damaged by carrier (e.g. airline)?

Yes  No

E13 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 the items?

Yes  No

If you selected 'yes' please go to E14, otherwise go to E15.

E14 Who have you claimed against? (please attach copies of correspondence)

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

Carrier	Date claimed	Amount refunded	Claim/reference number
	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	
	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	
	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	
	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	
	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	
	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	

E15 What items are you claiming for? Please note that baggage claims are subject to depreciation.

Item description	Place of purchase	Purchase date	Purchase price	Amount claimed	Proof of purchase
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
		<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/>	\$	\$	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>Totals:</b>			\$	\$	

## Section F. Delayed Luggage

Complete this section if you incurred out of pocket expenses for the replacement of essential items such as toiletries because your luggage was delayed by a carrier. Please note that if your luggage was not returned to you, we will reduce the amount that we pay for your claim under Section E (Luggage and Personal Effects) by the amount that we agree for your claim in this Section.

### Claims evidence we require under this section

- Itemised receipts for the purchase of essential items claimed by you.
- Property Irregularity Report (for your mislaid luggage) from the carrier and confirmation or any compensation paid to you.
- Ticket and baggage tags from the carrier who caused your luggage to be delayed.

F1 Who was the carrier who delayed your luggage?

F2 Did you receive compensation from the carrier for the delay?  Yes  No

If you selected 'yes' please go to F3, otherwise go to F4.

F3 What compensation did you receive?

F4 Where was your luggage delayed?

F5 What was your arrival time and date at this location?

Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Date	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y

F6 Was your luggage returned to you?  Yes  No

If you selected 'yes' please go to F7, otherwise go to F8.

F7 When was your luggage returned?

Time	<input type="checkbox"/> AM <input type="checkbox"/> PM
Date	<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y <input type="text"/> Y

F8 What essential items did you need to purchase following the delay?

Description of essential items purchased	Traveller item was purchased for	Purchase date	Time of purchase	Price paid (state currency)	Store where item was purchased
		<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> : <input type="text"/> AM <input type="text"/> PM	\$	
		<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> : <input type="text"/> AM <input type="text"/> PM	\$	
		<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> : <input type="text"/> AM <input type="text"/> PM	\$	
		<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> : <input type="text"/> AM <input type="text"/> PM	\$	
		<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> : <input type="text"/> AM <input type="text"/> PM	\$	
		<input type="text"/> D <input type="text"/> D <input type="text"/> M <input type="text"/> M <input type="text"/> Y <input type="text"/> Y	<input type="text"/> : <input type="text"/> AM <input type="text"/> PM	\$	
<b>Total:</b>				\$	

### Section G. Rental Vehicle Excess

Complete this section if you have incurred legal liability to pay an excess or deductible under a rental vehicle hiring agreement for loss or damage to a rental car you hired during your journey.

#### Claims evidence we require under this section

- Your rental agreement and confirmation of the insurance you selected including any waivers.
- A police report.
- A statement from the rental organisation showing the amount you were liable to pay.
- The repair invoice for the damage to the rental car.

G1 Who was the rental vehicle hired from?

Rental organisation name			
Address			
Phone number		Email	

G2 Who was the rental agreement issued to?

First Name	
Surname	

G3 What was the make and model of the rental vehicle?

Make	
Model	

G4 When did the rental period start?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

G5 When did the rental period end?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

G6 When did the accident giving rise to your loss happen?

Time		<input type="checkbox"/> AM	<input type="checkbox"/> PM
------	--	-----------------------------	-----------------------------

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

G7 Where did the accident happen?


G8 What were you using the rental vehicle for when the accident happened?


G9 Who was driving or who was in control of the rental vehicle when the accident happened?

First Name	
Surname	

G10 Do you consider yourself liable for the loss or damage to the rental vehicle?  Yes  No

G11 Did the police attend the accident?  Yes  No

G12 Was there another vehicle involved in the accident?  Yes  No

If you selected 'yes' please go to G13, otherwise go to G16.

G13 Who was driving the other vehicle?	First Name			
	Surname			
	Address			
	Country			
	Phone		Email	

G14 What was the make and model of the other vehicle?	Make			
	Model			

G15 Who is the insurer of the other vehicle?	Company			
	Location			

G16 What were the total repair costs for the rental vehicle? \$

G17 What excess were you liable to pay under your rental agreement? \$

G18 What excess was charged to you by the rental organisation? \$

G19 What were the circumstances that led to the accident? Please provide as much detail as possible, including pictures or diagrams to depict the event if helpful.

**Section H. Other**

Complete this section if you have incurred a loss which is not detailed elsewhere on the Claim Form. You will need to state the Policy Section under which you believe you have a claim and provide full particulars of the loss, including relevant dates and amounts that have been paid by you.

**Claims evidence we require under this section**

Any additional information such as reports from authorities which support your claim.

H1 Which policy section(s) describes your loss?

H2 What was the event date giving rise to your loss?

D	D	M	M	Y	Y	Y	Y
---	---	---	---	---	---	---	---

H3 How much are you claiming for?

\$

H4 What are the circumstances of your loss? Please provide as much detail as possible.

## Section I. Declaration

You must sign below

I/we (print name/s)

declare that the above answers and those contained in any attachments are true and note that AIG Insurance New Zealand Limited ('AIG') may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to provide AIG with assistance in dealing with this matter and understand that failure to co-operate with AIG and to provide all information relevant to the circumstance may result in my/our claim being denied.

### Authority

I/we authorise any person or entity (including any hospital, physician or other person who has attended me, my employer, my accountant and other professional advisers, financial institutions including banks and insurers, government departments including Inland Revenue, telecommunications and internet service providers, airlines, hotels, shipping agents, and/or travel agents) to furnish AIG or its representatives with:

- I. copies of hospital and medical reports/notes which AIG considers relevant to the claim;
- II. information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment) which AIG considers relevant to the claim; and
- III. copies of any other documents or records considered by AIG to be relevant to the claim and which may include copies of employment records, income tax returns and bank statements.

I/we agree that a photocopy of this authorisation shall be considered as effective and valid as the original and authorise its use as such.

### Untrue/False Information:

I/we agree to provide AIG or AIG representatives with all requested information or documentation relevant to our claim.

I am/we are aware that if I/we supply any untrue or false information and know it is not true, AIG shall have the right to refuse the claim in part or in full.

ICR (Insurance Claim Register Limited): I/we agree that AIG may obtain information from, or provide information to the ICR that is relevant to this claim, your previous claims or future claims. This may include personal information about you and your claim.

### Privacy

I/we consent to AIG in accordance with the Privacy Act 2020:

1. collecting holding and using personal information including information by audio, photographic or video surveillance, provided for the purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
2. disclosing personal information submitted to another AIG company located overseas, its staff members, the insured, other insurers and reinsurers, law enforcement agencies, investigators, lawyers, assessors, advisors, emergency providers, medical providers, travel carriers and the agent of any of these, insurance broker, insurance agent or intermediary, employer or other service provider to AIG for the purpose of administering my claim, including providing a report, data management and/or data analytics or claims recovery.

Information is provided voluntarily however if AIG does not collect this information, it may not be able to assess a claim. Insured persons have rights under the Privacy Act 2020 to access and correct their personal information. Further information about this or making a privacy complaint can be obtained by emailing: [Privacy.officerNZ@aig.com](mailto:Privacy.officerNZ@aig.com)

NOTE: AIG will only seek information which in its opinion it believes to be relevant to investigation of the claim.

Name	Date
	<input type="text" value="D"/> <input type="text" value="D"/> <input type="text" value="M"/> <input type="text" value="M"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/> <input type="text" value="Y"/>

Signature

If you are signing on behalf of the Insured person, please state your authority to do so and relationship. Please complete:

Name	Phone

Position of Authority's Relationship to Insured Person

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