HOW TO FILE A TRIP CANCELLATION / INTERRUPTION CLAIM

To assist us in processing your claim as quickly as possible, please do the following:

1. Complete and sign the attached claim form. To avoid unnecessary delay, please be sure to answer all questions in full and to sign the form where indicated.

2. Attach receipts for all expenses for which you are seeking reimbursement. If your claim is for reimbursement of airline tickets ONLY, you must submit the original airline tickets with your claim.

3. IMPORTANT: If you are making a claim due to medical reasons: You should have Part 5 the "Attending Physician Statement" completed by a qualified physician, and you must also sign the "Authorization for Release of Medical Information," as we may request a copy of your medical records.

4. Please note: We must have all applicable information in order to process your claim.

5. Send completed claim forms to DIVERS ALERT NETWORK ASIA-PACIFIC, PO Box 384, Ashburton, VIC 3147, Australia.

If you have any questions or need assistance in completing this form, please feel free to write, email or call us at:

PO Box 384 Ashburton, VIC

3147, Australia

Tel: +61 3 9886 9166; Fax +61 3

9886 9155

Email: info@danap.org

www.danap.org

Our Customer Service Representatives look forward to helping you.

TRIP CANCELLATION / INTERUPTION FORM

PART 1

First Name: _____ Family Name: _____

Date of Birth: DD/MM/YYYY DAN Member No: _____

Address: _____

City: _____ State: _____ P/Code:_____

Daytime Phone No. _____

PART 2 – Documentation of Dive Trip

Reason for Cancellation: _____

Name of Tour Company or Cruise Line:_____

Name, Address and Phone No. of Travel Agent (if Applicable)

_____

_____

Name of your Tour or Ship: _____ If Ship, Cabin No. _____

If not included in the Tour/Cruise package how were your air transfers arranged? _____ _____

_____

PART 3

Date of Initial Trip Deposit: DD/MM/YYYY Date of Final Trip Payment: DD/MM/YYYY

Amount paid for Tour/Cruise: $_____ Refund Due From Tour Co./Cruise Line: $_____

Amount being claimed under this insurance plan: $_____

PART 4

Date Sickness or Injury Began: DD/MM/YYYY Date Ended: DD/MM/YYYY

Nature of Sickness or Injury _____

_____

_____

Date of first treatment: DD/MM/YYYY If Hospitalised, dates confined: DD/MM/YYYY To DD/MM/YYYY

*Full Name, Address and Phone Number of Patient's Regular Physician:

_____

_____

*Full Name, Address and Phone Number of any other Physician(s) or Medical Suppliers from whom treatment was received:
(Attach additional sheets if necessary)

1. _____ Specialty: _____
2. _____ Specialty: _____

*If Hospitalised, Name & Address of Hospital(s) where treatment was received:
(Attach additional sheets if necessary)

1. _____
2. _____

AUTHORISATION FOR RELEASE OF MEDICAL INFORMATION

In order to process a claim for benefits, I authorize any physician, hospital or other medical provider to release to Divers Alert Network or the United States Life Insurance in the City of New York or their representatives any information regarding my medical history, symptoms, treatment, examination results or diagnosis. A photocopy of this authorization shall be considered as effective as the original. This authorization shall be considered valid for the duration of the claim, but not to exceed one year from the date signed. I understand that I have the right to receive a copy of this authorization.

Dated: DD/MM/YYYY

_____

Signature of person suffering illness or injury
(or legally authorised representative)

PART 5 – To be completed by the attending physician

The attending physician's statement below must be completed by the attending physician or other legally qualified physician (must not be completed by a physician who is a family member of the claimant or patient).

Name of Patient: _____ Date of Birth: DD/MM/YYYY

Date symptoms first appeared or accident occurred: DD/MM/YYYY

Date of first treatment: DD/MM/YYYY

Was Patient treated by someone else?: _____ If so, by whom?: _____

When? DD/MM/YYYY

(if applicable) Was Patient unable to dive as a result of this sickness or injury?: _____

If so, for how long?: _____

Has Patient previously received medication or other treatment for this condition, or a related condition, by you or any other physician?: _____ If so, please provide exact dates and details?: _____

_____

_____

_____

Date Completed: DD/MM/YYYY

_____

Signature of physician

Name of Physician (Please type or Print): _____

Address of Physician: _____

_____

Phone: _____ Fax _____

IMPORTANT NOTICE: Any person who knowingly and with intent to defraud any insurance company or other person files a statement of claim containing materially false information, or conceals for the purpose of misleading, information concerning any fact thereto, commits a fraudulent insurance act, which may be a crime.

Date: DD/MM/YYYY

_____

Signature

(Please note that all information requested on this form is necessary in order to process your claim)

This plan is underwritten by the United States Life Insurance in the City of New York

DIVE INJURY CLAIM FORM

for non-Australian Members

DAN Group Insurance Number:
Insurer: Accident & General Insurance

Member's Statement	**1. Primary DAN AP Member's Name:**		**2. DAN AP Member Number:** _ _ _____
	3. Patient's Relationship to Primary DAN AP Member *(tick one):* ☐ Self ☐ Spouse ☐ Child	**4. Patient's DAN AP Insurance Plan:** ☐ Standard ☐ Master ☐ Preferred ☐ Preferred Plus	**5. Insured's Patient's date of birth:** (dd/mm/yy) ____ / ____ / _____
	6. Insured Patient's name: Surname: _____ First name: _____ Middle Initial: _____		
	7. Insured Patient's home address: Street: _____ City: _____ State: _____ P/Code: _____ Country: _____ Tel (daytime): _____ Email: _____		
	ALL CLAIMS MUST BE: 'COVERED' IN-WATER DIVING OR SNORKELLING ACCIDENTS (Except for non-diving incidents covered under the Preferred Plus policy)		
	8. Where did the accident occur?		**9. Date of accident:** (dd/mm/yy): ___ / ___ / ____

10. Describe the situation which caused the injury: (NOTE: For diving incidents you must also include details of all dives in previous 72 hours with max. depths, times, stops & surface intervals. Also include what decompression guide was being used, eg. what tables or dive computer) *Use extra pages if needed and attach these.*

11. Describe the signs and symptoms of your injury and the first aid that was provided, if any.

12. Is this claim the result of a work or research-related illness or injury? *(tick one)*

☐ Yes

☐ No

13. Insured's Employer details *(if accident work-related)*

Employer: _____

Street: _____

City: _____ State: _____

P/Code: _____ Country: _____

13. What was the max. depth during dive (series): _____ **metres.**

14. Breathing gas used: ☐ Air ☐ Other, please specify _____

_____

15. Diving qualification(s) _____

16. When was a doctor first seen for this injury?

Date: (dd/mm/yy): ___ / ___ / ____ Doctor: _____

Other Insurer(s) Information

17. In addition to the DAN Group Insurance are you entitled to health or medical insurance benefits available from? *(tick 'Yes' or 'No' for all questions)*

Health, medical or dental insurance?	☐ Yes	☐ No	Travel Insurance?	☐Yes	☐ No
Medicare?	☐ Yes	☐ No	Accident Insurance?	☐Yes	☐ No
Any Statutory Insurance?	☐ Yes	☐ No			

18. If 'Yes' circled, please provide the full name and address of the insurance companies.

19. Have you, or will you submit a claim against any other party for damages as a result of the accident or injury described in this form?

☐ Yes ☐ No If Yes, please provide details:

Authorisat-ion to obtain information and assign benefits

20. Insured Patient or parent (in the case of a Minor) must sign below:

I hereby authorise any insurance company or prepayment organisation, employer, hospital or physician to release all information with respect to me or any of my dependants which may have a bearing on the benefits payable under this or any other plan providing benefits or services. I hereby certify the information provided is correct and true to the best of my knowledge. I also agree that a photostatic copy of this authorisation shall be as valid as the original.

Insured Patients signature	**Date** dd/mm/yy
	/ /

21. IF PAYMENT IS TO BE MADE TO PROVIDER, SIGN BELOW:

I hereby authorise payment of benefits otherwise payable to me for services, to any providers of service, but not to exceed the reasonable and customary charge for those services. I understand that I am financially responsible for any charges not covered by this authorisation.

Insured Patient's signature	**Date** dd/mm/yy
	/ /

22. I hereby state that any person who knowingly and with intent to defraud, or deceive any insurance company, files a statement of claim containing any false, incomplete or misleading information about the accident, injury or about other insurance coverage may prejudice the claim and the right to compensation forfeited.

Insured Patient's signature	**Date** dd/mm/yy
	/ /

THIS CLAIM CANNOT BE ASSESSED OR COMPENSATION PAID WITHOUT COPIES OF ALL OTHER INSURERS' EXPLANATION OF BENEFIT (EOB) FORMS. PLEASE ATTACH OR SEND AS SOON AS POSSIBLE. YOUR CLAIM WILL BE PENDED UNTIL THESE EOB'S ARE RECEIVED.	Please send the completed form and medical bills to: **DIVERS ALERT NETWORK Asia-Pacific Ltd** **ABN 67 066 827 129** **PO BOX 384** **ASHBURTON VIC 3147** **AUSTRALIA**