



BERKSHIRE HATHAWAY SPECIALTY INSURANCE

Accident & Health

CORPORATE TRAVEL INSURANCE CLAIM FORM

NOTIFICATION OF A CLAIM OR CIRCUMSTANCE THAT MAY GIVE RISE TO A CLAIM

YOUR INFORMATION

BHSI Policy Number:

Name of Your Employer: _____

Your Full Name: Dr. / Mr. / Mrs. / Miss _____

Your Position: ☐ CEO ☐ CFO ☐ COO ☐ CRO ☐ CIO ☐ Director ☐ Head of HR

☐ GM ☐ Company Secretary ☐ Employee ☐ Contractor

If none of the above positions, please specify (e.g. Spouse or Dependent Child):

Your Contact Details: Full Address: _____

Telephone: _____ Mobile: _____

Email Address: _____

TRAVEL INFORMATION

Date of Departure: _____ Date of Return / Expected Return: _____

Reason for Travel: ☐ Business ☐ Business & Leisure ☐ Leisure ☐ Other

If other, please specify: _____

Departure Country: _____ Departure City: _____

Destination Country: _____ Destination City: _____

INCIDENT DETAILS

Date of Event (accident/injury/sickness/damage/theft): _____

Country of Event: _____ City of Event: _____

Please describe how the accident/injury/sickness/damage/theft occurred:

Was the incident reported to police or any other law enforcement authority? ☐ Yes ☐ No

Police/Law Enforcement Report Number: _____

EMERGENCY ASSISTANCE PROVIDER – BHSI CARE & CONCIERGE

Has BHSI Care & Concierge been advised of the claim? ☐ Yes ☐ No

If yes, please provide Case Number: _____

OTHER INSURANCE

Did you pay for your trip on a Credit Card? ☐ Yes ☐ No

If yes, please provide the name of the financial institution and card type (e.g. Platinum or Gold Visa): _____

Did you purchase any other travel insurance policy for this trip? ☐ Yes ☐ No

If yes, please provide the name of the travel insurance provider & your policy number: _____

Do you have Home & Contents Insurance? ☐ Yes ☐ No

If yes, please provide the insurer name and policy number: _____

Are you entitled to claim Medical Benefits:

Under the Accident Compensation Act (2001)? ☐ Yes ☐ No

Under any Reciprocal Health Agreements? ☐ Yes ☐ No

Under any Private Health Insurance? ☐ Yes ☐ No

If Yes, please provide details:

OVERSEAS MEDICAL EXPENSES CLAIM

Injury/Illness/Sickness Information

Describe the injury/illness/sickness:

Claim Information

Date Expense Incurred	Details of all Medical Treatment	Amount (NZD or Local Currency)
Total Amount Claimed (NZD or Local Currency)		\$

CANCELLATION AND DISRUPTION CLAIM

Travel Amendment or Cancellation Claim

Date Travel Disrupted
or Cancelled: _____

Date You Were
Due to Depart: _____

Reason for Disruption or Cancellation:

Details of the Changed Itinerary:

Airfares/Airline	Accommodation	Currency (NZD or Local)	Amount Paid	Amount Refunded	Amendment Cost	Cancellation Cost
Subtotal Amount Claimed (NZD or Local Currency)			\$	\$	\$	
Total Amount Claimed (NZD or Local Currency)						\$

Additional Expenses Claim

Reason for Additional Expenses:

Expense Detail	Date Expense Incurred	Amount (NZD or Local Currency)
Less any compensation received from airline, hotel etc.:		\$
Total Amount Claimed (NZD or Local Currency)		\$

BAGGAGE & PERSONAL EFFECTS CLAIM

Have you submitted a claim for compensation for lost baggage or personal effects from your transport provider?

☐ Yes ☐ No

If no, you will need to submit a claim for compensation to your transport provider before submitting a claim to us.

Claim Details

Item	Date Purchased	Personal Effect?	Business/Company Owned?	Replacement Amount (NZD or Local Currency)
Less amount paid in compensation by either the transport provider or any other insurance:				
Total Amount Claimed (NZD or Local Currency)				\$

RENTAL VEHICLE EXCESS WAIVER CLAIM

Is this claim related to a rental vehicle?

☐ Yes ☐ No

Was the vehicle rented from a licensed rental agency?

☐ Yes ☐ No

Details of the accident/damage/theft:

Rental Vehicle Excess Waiver amount you are liable to pay the rental agency:

\$

Total Amount Claimed (NZD or Local Currency)

\$

SUPPORTING DOCUMENTATION REQUIRED

Please attach the following documentation for the sections you have completed on this form.

- Your travel itinerary or tickets

Overseas Medical Expenses Claim

- Medical certificate and reports
- Original medical receipts

Cancellation & Disruption Claim

- Travel receipts, accounts or letter from travel agent/airline/hotel
- Medical certificate or letter from physician or doctor confirming reason for amendment or cancellation (if applicable)
- Refund advice from agent/airline/hotel

Baggage & Personal Effects Claim

- Proof of ownership of lost, damaged or stolen items (invoices, receipts)
- Police, airline incident report or event number
- Response from transport provider after claim for lost/delayed luggage (where applicable)

Rental Vehicle Excess Waiver Claim

- Rental agreement showing the excess amount you were liable to pay
- Police report or police event number (where available)
- Repair invoice or quote

PAYEE'S ELECTRONIC FUNDS TRANSFER (EFT) DETAILS AND TAX STATUS

Following approval of your claim, we will pay your claim directly into your bank account. To enable us to do so, please provide the following details:

Name of Financial Institution: _____

Account Name: _____

Bank Code: _____ Account Number: _____

Bank Swift Code (International Payments): _____

Bank Account Currency (International Payments): _____

Bank Address (International Payments): _____

Please note that we are not liable for any bank processing fees incurred by you.

Is the Payee tax resident in New Zealand? ☐ Yes ☐ No

If not, is the Payee registered for GST? ☐ Yes ☐ No

DECLARATION

I declare that the above statements are true and correct and that I understand that:

- this claim form may collect personal information;
- Berkshire Hathaway Specialty Insurance Company ("BHSIC") requires this information pursuant to my/our insurance policy ("Policy") and to evaluate this claim;
- the Privacy Act 2020 entitles me/us to have access to, and request correction of, any personal information retained by BHSIC;
- BHSIC is authorised to collect personal information relevant to the Policy and this claim from third parties;
- BHSIC may make my/our personal information available to third parties to administer the Policy and this claim, or when required by law to do so; and
- where I am/we are providing personal information to BHSIC regarding another individual, I/we have:
 - obtained any legally-required consent for the collection, use disclosure and transfer of personal information about that individual in accordance with this Privacy Declaration; and
 - informed them about the content of this Privacy Declaration, and that further information about the collection, use, storage and destruction of their personal information is available from:
<https://www.bhspecialty.com/privacy-policy/privacy-policy-new-zealand/>

Name: _____ Position: _____

Signature: _____ Date: _____

Email: ahclaimsnewzealand@bhspecialty.com

Phone: 0800 446 006

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