

Complete this form if your claim is due to an accident, illness, disability or death.

The form must be completed by the patient (injured, ill or disabled person) whose illness or injury resulted in this claim or Executor of the Estate in the event of a death.

I authorise Kogan or its representatives to obtain from any person or organisation any information regarding treatment for the condition(s) which resulted in this claim. I acknowledge that a photocopy of this authorisation shall be considered as valid as the original.

Policy Number:

Claim Number:

Patients Full Name:

Patients Date of Birth:

Patients Signature:

Executor of the Estates Full Name (if applicable):

Executor of the Estates Signature (if applicable):

Name of Patients Usual Doctor/Dentist in Australia:

Doctor/Dentists Phone Number:

Doctor/Dentists Fax Number:

Doctor/Dentists Email Address:

Doctor/Dentists Postal or Practice Address:

Suburb:

State:

Postcode:

Please return completed form to Kogan Travel Claims

Email Address travel.claims@koganinsurance.com.au (Please include claim number in email subject)

Phone Number 1300 034 888

Fax Number 02 8883 7003

Postal Address Kogan Travel Claims
Locked Bag 2010
St Leonards NSW 1590