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Personal Accident or Sickness Claim

The issue of this form does not constitute an admission of liability on the part of the insurer.

Policy Number | Due Date

Full Name

Date of Birth | Sex | Height | Weight

Street Address

Suburb/City | State | Postcode

Work Phone | Work Fax | Mobile

Home Phone | Email

Occupation Prior to Disablement

Describe your usual work duties

Please give a full description of the injury or sickness for which you are claiming. Including a full description of the accident giving rise to these injuries including names and addresses of any other parties involved and witnesses (attach statement if there is insufficient space).

a) Sickness Date of sickness

Condition

When did it commence?

b) Injury Date of Injury

What were you doing at the time?

Describe injuries you received?

Which Police Station notified? Date

Have you ever had this, or a similar condition in the past? .....Yes No

If you answered yes

Conditions

Date(s)

Treated by

When did you first consult a doctor for the condition? Date Time

When did you become totally disabled (unable to work)? Date Time

If still totally disabled when do you expect to return to work? Date Time

If you have returned to work, when were you able to again perform:

a) part of your occupational duties? Date Time

b) all of your occupational duties Date Time

If you were admitted to hospital, or treated as an outpatient, please give details.

a) inpatient Hospital Name

Address

Date From Date To

b) outpatient Hospital Name

Address

Date From Date To

Give details of all attending physicians

Doctor's Name	Address	Telephone

Who is your usual physician?

Your Doctor's Name	Address	Telephone

What other medical or surgical treatment has been received during the past five years? (Give dates, nature of sickness or injury and names and addresses of all treating doctors, hospitals, and clinics).

Date	Nature of Sickness or Injury	Doctor's Name	Hospital/Clinic Address

Are you now, or have you ever been, subject to or affected by any other injury or disease, deformity, defect of senses, infirmity or weakness? If so, please give details.

Have you ever lodged a Personal Accident or Sickness claim before? Yes ☐ No ☐

If yes, please give details.

Insurer			
Address			
Policy Number		Claim Number	
Details			

Are you making any other insurance or compensation claim in respect of this disability?

Worker's Compensation/Workcare	☐ Yes	☐ No
Government Benefits	☐ Yes	☐ No
Motor Accident Law	☐ Yes	☐ No
Superannuation Life Assurance	☐ Yes	☐ No
Other (please specify) _____	☐ Yes	☐ No

Information Authority & Warranty

I, ...

hereby authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish my insurance company or it's representative with:-

(i) All copy hospital and medical reports/notes;

(ii) All copy employment records and income tax returns; and

(iii) All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment), employment history and income tax returns.

I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that my insurance company relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Date: _____ Signature: _____

IF SELF EMPLOYED
(Please submit documentation to validate earnings)

(a) What are your average weekly earnings, net of expenses, but before tax? $

(b) Do you operate as a Proprietary Limited Company? Yes ☐ No ☐

(c) Do you or your company pay worker's Compensation/Workcare levy? Yes ☐ No ☐

(d) What is your Business Trading Name?

ABN | Commenced Trading | to

Street Address

Suburb/City | State | Postcode

Telephone | Email

(e) Who is your Accountant?

Street Address

Suburb/City | State | Postcode

Telephone | Email

IF EMPLOYED AS A WAGE EARNER
(to be completed by your employer)

Company Name

Street Address

Suburb/City State Postcode

Name of Paymaster or Supervisor

Telephone Email

I hereby certify that employed since

has been unable to attend to their usual occupation with the company as a result of;

a) injury b) injuries c) sickness

suffered whilst on date

incapacitated since a) expected to b) did resume on date

Her/His average weekly salary (excluding bonuses, commissions, overtime payments and other allowances) for the 12 months prior to the injury or sickness. $

During the period of incapacity s/he received

Normal Pay	$	From		To	
Sick Pay	$	From		To	
Worker's Compensation	$	From		To	
Other (please specify)	$	From		To	

Company Stamp

Signature of Paymaster or Supervisor: _____

Name (Please Print): _____

Date: _____

Privacy

The Privacy Act 1988 requires us to tell you that we as broker and the insurer collect your personal and sensitive information in order to calculate your loss and entitlements, determine the insurer's liability, compile data and handle claims.

When handling claims we and the insurer may have to disclose your personal and other information to third parties such as other insurers, reinsurers, loss adjusters, external claims data collectors, investigators and agents, or other parties as required by law.

Where you give us information about other persons you must have their consent to this and provide it on their behalf. If not, you must tell us.

You have the right to seek access to your personal information and to correct it at any time. Please contact us to advise if any changes are required.

Internal Dispute Resolution (IDR) Statement

Disputes are not an everyday occurrence. However insurers provide an internal dispute resolution process should any dispute arise. Please feel free to ask for details. If you are not satisfied with the outcome of that process, we will advise you how to contact the insurance industry's external independent complaints scheme (subject to eligibility).

Declaration (must be completed)

1. I/We the insured do solemnly and sincerely declare that I/We have complied with the conditions and warranties (if any) of the policy and have not deliberately caused the said loss or damage or sought unjustly to benefit thereby by any fraud or misrepresentation and that the information shown on the form is true and the I/We have not concealed any information relating to this claim. I/We understand that this claim may be refused if the information is untrue, inaccurate or concealed.

2. Further it is understood and agreed that if any property claimed for is subsequently recovered in an undamaged condition I/We will immediately refund the company any sum which may have been paid to me/us in respect of such property. In the event of any property being recovered in damaged condition I/We will immediately hand the same over to the company for disposal as may be agreed.

3. I/We acknowledge that I/we have read and understood the Privacy Act information referred to above and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons affected by this claim.

4. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information, then the broker and the insurer will be unable to process my/our claim.

Date: _____ Signature:_____

Electronic Funds Transfer Authority

Section 1 Name (of policy holder)

Title: ☐ Mr. ☐ Mrs. ☐ Miss ☐ Company

Name: _____

Section 2 Bank Account Details

BSB number (all 6 digits are required here) Account Number

☐☐☐☐☐☐ ☐☐☐☐☐☐☐☐

Nominated account name: _____

Bank, Credit Union, Building Society name: _____

Branch: _____

Section 3 Declaration

I hereby authorise my Insurer to make any payments to the policy holder by Electronic Funds Transfer (EFT) into the above bank account.

Signature if individual: _____ **Date:** _____

Signature if Company: _____ **Date:** _____

Print Name: _____

How To Get Quick Action On Your Claim

1. Complete the attached form and return to our office. If an assessor is appointed, give them the forms.

2. Attach all **original** quotations or invoices obtained for replacement of or repair to the damaged or missing property. Photocopies are not accepted as a rule.

3. Attach **original** valuations and receipt of purchases whenever possible.

4. Advise the Police immediately in the event of loss by burglary, housebreaking, theft, suspected malicious damage. Also make sure the premises are secure to avoid further incidents.

   Note: Police reports are very slow so if you can obtain one at the time the report is taken, then this will save valuable time or at least obtain a copy or report number.

5. Attach any letter of demand or other correspondence that you may receive from any Third Party.

6. Do not make any admission of liability for loss or damage caused by you to the Third Parties.

WHAT WE WILL DO - IF THE PAPERWORK IS CORRECT AND COMPLETE:-

- Submit the claim form to the Insurer
- If the claim has not been paid within 30 days we will contact the Insurer and then advise you accordingly
- We will then follow up the claim when necessary until settlement is reached, however, please feel free to call at any time

WHAT AN ASSESSOR WILL DO:-

- An assessor is an independent person who is appointed by the Insurer for their expertise in helping you finalise a larger or more difficult claim
- They will interview and obtain details of a loss and arrange for quotes and prepare the necessary paperwork
- The assessor is your contact point
- The assessor will write a report to the Insurer recommending a course of action
- This can take time depending on their work load and Police Reports
- The Insurer will not act until these reports are received and although not bound by the assessor recommendations, the Insurers usually accept these reports.
- If you are unhappy with any aspect of the claim, advise the assessor. If he is unable to correct the problem then contact us immediately. We will not know of any problem without being advised.
- If you are unhappy with the assessor's responses, contact us immediately.

RESET | SAVE | PRINT | SUBMIT

Please click submit to send the form electronically. You will then have to select desktop email or webmail. If you use Microsoft Outlook or similar select desktop mail and a new email will automatically open with the completed PDF attached, then click send.