

CLAIM REPORT FORM

FOR DISABILITY AS A RESULT OF AN ACCIDENT OR SICKNESS



IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. *This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim. Please note that sections 1,4,6 & 7 are compulsory.*
2. When completing this form please print.
3. The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Ltd.

SECTION ONE: POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

Policy Number: _____ Expiry Date: _____

Name of Policy Holder _____

Name of Insured Person _____

Surname _____ Given Names _____

Residential Address _____

State _____ Postcode _____

Telephone No. Home _____ Business _____

Mobile _____ Email _____

Occupation, Trade or Profession _____

Date of Birth _____ / _____ / _____

Please tick preferred form of payment for refund
 Cheque Direct Payment If you have selected Cheque please nominate payee _____

If you have selected Direct Payment please supply the following information (alternatively supply a deposit slip noting the following information)

Bank _____ Account Name _____

Branch Number _____ Account Number _____

SECTION TWO: TO BE COMPLETED ONLY IF DISABILITY IS AS A RESULT OF AN ACCIDENT / INJURY

Address where accident occurred: _____

Time: _____ am/pm Date: _____ / _____ / _____

Were there any witnesses to the Accident? Yes No

Witness Name: _____

Witness Address: _____

Exactly How did the Accident happen? _____

What were the injuries? _____

Have you previously been treated for any serious injury? Yes No

If Yes, please give details: _____

Give details of any previous claim made for any previous injury against any insurance company: (please attach separate sheet if insufficient space)

Period of Insurance (from / to)	Company Name	Company Address

SECTION THREE: TO BE COMPLETED IF DISABILITY IS AS A RESULT OF A SICKNESS / ILLNESS

The nature of illness _____

When did the illness begin? _____ / _____ / _____ Have you had this complaint before? Yes No

If Yes, how long were you disabled? _____

Accident & Health International
Underwriting Pty Limited

SECTION FOUR: TREATMENT – COMPULSORY SECTION – REQUIRES COMPLETION

Was hospital treatment required?

Yes No

If Yes, please complete the following (please attach separate sheet if insufficient space)

Hospital Stay			
From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

When did you stop work? Time _____ am/pm Date ____/____/____

When did you first obtain treatment from doctor? Time _____ am/pm Date ____/____/____

Name of Doctor _____

Address _____

Is this doctor still treating you for the injury / illness? Yes No

Is this doctor your regular doctor? Yes No
If No, please give details

Regular Doctor's Name _____

Address _____

Is there any condition (past or present) affecting your current disability? Yes No

If Yes, please give details _____

Are you now:

Recovered When did you return to work? ____/____/____

Partially Disabled When did you return to work undertaking part of your normal activities? ____/____/____

Totally Disabled When do you expect to return to work? ____/____/____

Have you made, or will you make, a claim for benefits under any Workers' Compensation Act or Ordinance because of this injury? Yes No

If Yes, please give details

Name

Address

Employer _____

Workers Comp. Insurer _____

Claim Number (if known) _____

Are you entitled to claim benefits for this illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? Yes No

If Yes, please give details:

Name

Address

SECTION FIVE: TO BE COMPLETED ONLY IF CLAIMING FOR LOSS OF INCOME

1. IF SELF EMPLOYED PLEASE INDICATE BY TICKING THE BOX

Confirmation of earnings MUST be submitted with claim form (eg. Income Tax Return)

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

2. IF EMPLOYED AS A WAGE EARNER TO BE COMPLETED BY YOUR EMPLOYER

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an Injury / Illness suffered whilst _____ on the ____ / ____ / ____

He/She has been incapacitated since ____ / ____ / ____ and is expected to/did resume duties on ____ / ____ / ____

His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was _____ p.w.

During the period of incapacity he/she received:

\$ _____ from ____ / ____ / ____ to ____ / ____ / ____

Please specify type of pay _____

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

Has been employed since ____ / ____ / ____

Name of Company _____

Address _____

Signature of Supervisor or Paymaster _____ Name (Please Print) _____

Telephone Number _____ Date ____ / ____ / ____

SECTION SIX: DECLARATIONS – COMPULSORY SECTION – REQUIRES COMPLETION

Dispute Resolution Statement

Accident & Health International Underwriting Pty Ltd is an agent for Allianz Australia Insurance Limited who is a signatory to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd staff you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within fifteen (15) working days.

If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme.

Access to the Dispute Resolution scheme is free of charge to you.

PLEASE ARRANGE FOR THE MEDICAL CERTIFICATE SECTION OF THIS FORM TO BE COMPLETED BY THE DOCTOR WHO YOU CONSULTED FOR THIS INJURY OR SICKNESS

Declarations and Medical Authority

Privacy:

The Privacy Act 1988 requires us to tell you that on behalf of the Insurer we collect your personal information and sensitive information in order to calculate your loss and entitlements, determine our liability, compile data and handle claims.

When handling claims we may have to disclose and obtain your personal and other information to and from third parties such as other insurers, reinsurers, loss adjusters, medical attendants, external claims data collectors, investigators and agents, to the Insurance Reference Services (IRS), or other parties as required by law.

You have the right to seek access to your personal information and to correct it at any time. Please contact Accident & Health and advise us of the changes.

Medical Authority:

I authorise any doctor or medical attendant who has treated me or examined me or any person or organisation that employs or has employed me or any other person or organisation who has or may have information regarding my illness/injury to give the underwriter any information it requires to assist in the proof and settlement of my claim. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

Declaration:

I/We certify that the information given in this form is truthful accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We acknowledge that I/We have read and understood the Privacy Act 1998 information and Medical Authority referred to above and consent to the collection, storage and use and disclosure of my/our personal and sensitive information. I/We acknowledge that if I/We do not agree to the collection of this personal and sensitive information then Accident & Health will be unable to process my/our claim.

Date ____ / ____ / ____

Signature of the Insured
(If other than Claimant) _____

Date ____ / ____ / ____

Signature of the Claimant _____

ATTENDING PHYSICIANS STATEMENT
THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM
WITHOUT EXPENSE TO THE COMPANY



SECTION SEVEN: COMPULSORY SECTION – REQUIRES COMPLETION

1. Patient's Name _____
2. Please give complete diagnosis of this condition _____

HISTORY

1. When did the patient first receive medical treatment? _____ / _____ / _____
2. a) Is there a previous history of this or a similar condition? Yes No
 b) If Yes, please provide details _____
3. a) How long have you known the patient? _____
 b) Are you the regular general practitioner? _____
 If not, please advise who is _____

INJURY / SICKNESS

1. When did the patient first suffer the injury? _____
 2. What was the cause of the injury? _____
- OR
3. When was sickness first contracted? _____ / _____ / _____ When did symptoms become evident? _____ / _____ / _____

DEGREE OF DISABILITY

1. When was patient obliged to cease work? _____
2. When was/will the patient be/able to return to:
 a) Some duties? _____ / _____ / _____ OR b) Full duties? _____ / _____ / _____

TREATMENT OF PRESENT CONDITION

- When were you consulted? a) Initially _____ / _____ / _____ b) Most recently _____ / _____ / _____
- Was patient confined to hospital? Yes No Period of confinement _____ / _____ / _____ To _____ / _____ / _____
- If Yes, please advise Name and Address of hospital _____
- What other surgical or medical procedures are possibly contemplated? _____
- Are there any underlying conditions affecting recovery from the current conditions? Yes No
- If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery _____
- What is the current prognosis? _____
- Are there any further remarks which may assist in assessing this condition? _____

Date _____ Signature _____ Qualification _____

Name (Please print) _____ Address _____

City or Town _____ State _____ Telephone _____

Accident & Health International
Underwriting Pty Limited

ABN 26 053 335 952
 Level 32, 60 Margaret Street, Sydney, NSW 2000, Australia
 GPO Box 4213, Sydney, NSW, 2001, Australia. Phone +61 2 9251 8700 Fax +61 2 9251 8755 Freecall: 1800 618 700 Freefax: 1800 618 755