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ACCIDENT & HEALTH INTERNATIONAL

Claim Form

PERSONAL 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.
2. **Please note that Sections 1, 2, 5, 7 & 8 are compulsory.**
3. **Note: This form can be completed electronically. If completing this form by hand: Please print.**
4. **The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Limited.**

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

Policy Number

Expiry Date

Name of Insurance Broker *(if known)*

Name of Insured Company

Title

Given Name(s)

Gender ☐ M ☐ F

Family Name

Date of Birth

Residential Address

Suburb

State

Postcode

Email Address

Daytime Contact Number

Alternative Number

Occupation, Trade or Profession

Usual Duties

SECTION TWO: PAYMENT DETAILS - COMPULSORY

Please tick preferred method of Payment for refund.

☐ Cheque

Payee

☐ Direct/EFT Payment

Account Holder's Name

BSB Number (6-Digits)

Account Number

Bank

SECTION THREE: DETAILS OF ACCIDENT - COMPLETE IF AS A RESULT OF AN ACCIDENT

Date of Accident ☐☐☐☐☐☐☐☐ Time ☐☐☐☐ AM / PM ☐☐

Address where accident occurred:

Were there any witnesses to the accident? ☐ Yes ☐ No

Witness Name:

Witness Address:

Please describe how the accident / injury occurred:

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)

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

The nature of illness:

When did the Illness begin? ☐☐☐☐☐☐☐☐

Have you had this complaint before? ☐ Yes ☐ No

If Yes, how long were you disabled? ☐☐ Days ☐☐ Months ☐☐ Years

SECTION FIVE: TREATMENT - COMPULSORY

Was hospital treatment required? ☐ Yes ☐ No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

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 ☐☐

When did you first obtain treatment from doctor? ☐☐☐☐☐☐☐☐ Time ☐☐☐☐ AM / PM ☐☐

Name of Doctor | Address

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

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

Name of Regular Doctor | Address

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

If Yes, please give details

Are you now:

Recovered ☐ Yes ☐ No

Partially Disabled ☐ Yes ☐ No

Totally Disabled ☐ Yes ☐ No

When did you return to work? ☐☐☐☐☐☐☐☐

When did you return to work undertaking part of ☐☐☐☐☐☐☐☐

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 Transportation Act because of this injury? ☐ Yes ☐ No

If Yes, please give details

	Claim Number (if known)	Name	Address
Employer			
Workers Comp / Transport Insurer			

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

If Yes, please give details

Name	Address

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

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

1. IF SELF EMPLOYED PLEASE INDICATE BY TICKING THE BOX ☐

Confirmation of earnings MUST be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

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 $ _____ per week.

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)

Name of Company _____ Has been employed since ☐☐☐☐☐☐☐☐

Address _____

Signature of Supervisor or Paymaster _____ Date ☐☐☐☐☐☐☐☐

Name (Please Print) _____ Telephone Number _____

SECTION SEVEN: DECLARATION - COMPULSORY

Dispute Resolution Statement

Accident & Health International Underwriting Pty Ltd is an agent for our insurers who are signatories 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, 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.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

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 agree that, by submitting this form, the personal information I/We provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in our Privacy Policy including for the processing of this claim.

Authority

I authorise any hospital and/or physician who has treated me to provide Accident & Health International with copies of medical records or of my past medical history, as requested.

Signature of Claimant _____

Date ☐☐☐☐☐☐☐☐

Signature of the Insured *(if other than claimant)* _____

Date ☐☐☐☐☐☐☐☐

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MEDICAL CERTIFICATE

THE CLAIMANT MUST OBTAIN AT OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES

IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRES

SECTION EIGHT: PATIENT DETAILS - COMPULSORY

Full Name

Date of Birth

Please give complete diagnosis of this condition

HISTORY

When did the patient first receive medical treatment?

Is there a previous history of this or a similar condition? ☐ Yes ☐ No

If Yes, please provide details

How long have you known the patient? ☐☐ Days ☐☐ Months ☐☐ Years

Are you the regular general practitioner? ☐ Yes ☐ No If not, please advise who is

SICKNESS

When was sickness first contracted?

When did symptoms become evident?

OR

INJURY

When did the patient first suffer the injury?

What was the cause of the injury?

DEGREE OF DISABILITY

When was patient obliged to cease work?
Date

When was / will the patient be / able to return to:
Some Duties?
Full Duties?

TREATMENT OF PRESENT CONDITION

When were you consulted?
Initially
Most recently

Was patient confined to hospital? ☐ Yes ☐ No
From
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?

Print Name:

Qualification:

Signature:

Address:

Phone:

Fax

Date