Accident & Health International
Underwriting Pty Limited

Accident and Health

PERSONAL ACCIDENT &/OR SICKNESS CLAIM FORM

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

Sydney
Level 4, 33 York Street
Sydney NSW 2000
GPO Box 4213, SYDNEY NSW 2001
T: +61 2 9251 8700
F: +61 2 9251 8755

ABN 26 053 335 952
AFS Licence No: 238261
Email: enquiries@acchealth.com.au
Website: www.acchealth.com.au
Freecall: 1800 618 700
Freefax: 1800 618 755

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? ....

SECTION FOUR: TREATMENT – COMPULSORY SECTION – REQUIRES COMPLETION

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 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? (If No, please give details) Yes ☐ No ☐

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 Transportation Act because of this injury? Yes ☐ No ☐

If Yes, please give details

Name Address

Employer ....

Workers Comp./ Transport Insurer ....

Claim Number (if known) ....

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 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 (i.e. Income Tax Return & Profit/Loss Statement)

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 Authorities

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.

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 ....