Personal Accident and Sickness Insurance

Claim form

PLEASE ENSURE:

- You fully complete every question before your doctor completes their statement. Failure to do so will result in delay in handling your claim;
- You have enclosed all relevant supporting documentation including x-ray & other scan reports, a completed Tax File Number Declaration and proof of pre-Disability income;
- You have signed the Declaration and Authority on this claim form;
- Your attending doctor has fully completed the Medical Statement;
- **All medical certificates must state the reason for your disablement (e.g. "medical condition" cannot be accepted).**

SECTION 1 – TO BE COMPLETED BY CLAIMANT

1. Name of Insured:
2. Policy Number:
3. Full Name of Insured Person:
4. Date of Birth:
5. Address:

   Suburb: Post Code:
6. Occupation:
7. Telephone Business: Mobile:
8. Telephone Home:
9. Email:

SECTION 2 – TO BE COMPLETED BY CLAIMANT

CLAIMS FOR INJURY/ILLNESS/DEATH

Please state fully:

10. What is the Injury or Illness?

11. If Injury, how exactly did it occur?

12. When did the Injury occur? Date: Time: ☐ am ☐ pm
13. Or when did the Illness begin or first manifest itself? Date:
14. And when was the Illness first diagnosed? Date:
15. Did the Injury or Illness cause you to stop work? ☐ Yes ☐ No

    If 'Yes', when?
16. Have you returned to work full-time? ☐ Yes ☐ No

    If 'Yes', when?

17. Have you returned to work part-time? ☐ Yes ☐ No

    If 'Yes', what hours are you working? Days: Hours:

18. Describe your usual pre-Injury Duties:

19. Who is your usual GP or family doctor?

    Name:

    Clinic/Medical Centre:

    Address:

    Telephone Number:

20. When did you first see your usual doctor for this condition?

21. When did you first get treatment from any medical practitioner for this condition?

22. Date of first Consultation or Emergency Department visit?

    Name of this Doctor or Hospital:

    Address:

    Telephone Number:

23. Were you hospitalised for this condition? ○ Yes ○ No

    If 'Yes', when? To:

    At which Hospital?

    Detail all surgery performed:

24. What other treatment have you had or has been recommended?

25. During the 24 hours before the Injury, did you drink any alcohol or take any drugs? ○ Yes ○ No

    State types and quantities: Type: Quantity:

26. Have you ever suffered this Injury/Illness or a similar condition before? ○ Yes ○ No

    If 'Yes', give details:

27. Are you affected by any long tem or chronic disability? ○ Yes ○ No

    If 'Yes', give details:

OTHER INSURANCE/BENEFITS

28. Do you have Private Health Insurance? ○ Yes ☐ No

    ○ Hospital Only ☐ Extras

29. Are you entitled to, and/or have you now made, or intend to make, a claim for benefits of any type in regard to this Injury or Sickness? This includes Workers' Compensation, Traffic Accident Commission, CTP, sports association policy and any Income Protection Policy including those taken out through your Superannuation Fund: ○ Yes ○ No

    If 'Yes', give details:

    Name of organisation/Insurer:

    Name of Insurer and Contact Details:

Type of cover:

Claim Number: Policy Number:

Amount Claimed/Claimable:
(Attach a copy of the claim acceptance letter, Benefit Statement, other correspondence).

Name of Superannuation Fund:
Please confirm you have checked whether you have any Income Protection Cover with your Fund: ○ Yes ○ No

PRIVACY STATEMENT

Proclaim are committed to protecting your privacy. We use the personal information you provide to us in connection with your claim only for the purpose of assessing and managing the claim. We may need to provide that information to our underwriters and those we appoint to assist us with the claim. We will not trade, rent or sell your information. If you do not provide us with complete information, we cannot properly assess your claim. You can check the personal information we hold about you at any time. If you provide us with personal information about anyone else, we rely on you to have told them that you will provide their information to us, to whom we may provide it, the purposes for which we will use it and that they can access it. If the information is sensitive, we rely on you to have obtained their consent on these matters. For more information about our Privacy Policy, please refer to: https://proclaim.com.au/proclaim-privacy-policy/

DECLARATION AND AUTHORISATION - COMPLETE FOR ALL CLAIMS

I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim**.**

I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim or its representatives with any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports.

I authorise any Employer, Insurer, Superannuation Fund or other organisation or body through which I am or may claim similar benefits to furnish Proclaim with all information with respect to coverage and claims for this Sickness or Injury to enable assessment of my claim.

I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Signed: Date:

Name:

PAYEE'S BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.

30. Please complete the following:

Bank:

SWIFT code (For Non-Australian Bank): | | | | | | | | | | | |

Account Holder's Name(s):

BSB Number: | | | | | | | Account Number: | | | | | | | | | | | | | | | | |

EMPLOYER STATEMENT

31. Claimant Name:
32. When did Claimant cease work due to this Injury/Sickness?
33. Date claimant was employed by the Company?
34. Gross Weekly Salary averaged over the last 12 months prior to the date of disablement: $
    Please attach pay report.
35. Did the Injury occur at work? ○ Yes ○ No

    If 'Yes', when will/was the Workers' Compensation Claim lodged?

    If 'Yes', what is the Weekly Compensation? $
    Please attach all WorkCover correspondence.
36. What payments have been made to date during the period of disablement?

    WorkCover: $ From: To:

    Normal Pay: $ From: To:

    Sick Pay: $ From: To:
37. Claimant's Job Title:
38. What are his/her usual duties?
39. Has the Claimant returned to work? ○ Yes ○ No

    If 'Yes', on what date?
40. Name of Company:
41. Contact Details:

    Address:

    Suburb: State: Postcode:

    Telephone Number:

    Email:

    Name:

    Position:

    Signature: Date Completed:

THIS SECTION MUST BE FULLY COMPLETED BY ATTENDING DOCTOR.
ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON.

SECTION 3 – DOCTOR'S STATEMENT

42. Patient's Name:
43. Date of Birth:
44. Height: Weight:
45. Date of Onset of Sickness/Date of Injury:
46. When did you first examine the patient?
47. Please give full details of circumstances of Injury/onset of Illness:

48. Please detail the patient's symptoms:

49. What was your clinical diagnosis?

50. If not with you, when did the patient first receive medical attention for this condition?
    From whom:
51. Has the patient ever suffered with this or any similar condition before the present episode? ○ Yes ○ No
    If 'Yes', please give details including dates treatment and consultation:

52. Are you the patient's usual doctor? ○ Yes ○ No
53. If 'No', please give name and address of claimant's usual doctor:

DISABILITY:

54. On what date did incapacity commence?
55. Is patient still incapacitated? ○ Yes ○ No
    If 'Yes', please estimate when you estimate the patient to be able to return to work?
    Or, Please complete: I estimate the patient should have functional capacity to return to work in days or weeks
    or months, or other:
    I intend to review the patient on:
    If the patient is no longer disabled, when did he/she return to work?
    Please detail any investigations and provide results:

56. Any other comments/clinical findings?
57. Was the patient hospitalised as a result of this condition? ○ Yes ◉ No
    If 'Yes', which Hospital?
58. How many days was the patient hospitalised? Days From: To:
59. Detail any Surgical Procedures performed or planned:
    Procedure: Date performed/to be performed:
    Procedure: Date performed/to be performed:

60. Have you referred the patient to any other Medical Practitioner? ○ Yes ○ No

If 'Yes', Name and Speciality:

61. Detail any Treatment recommended? i.e. physiotherapy:

62. Is there any other Injury, Illness or condition impacting the patient's recovery from the claimed condition? ○ Yes ○ No

If 'Yes', give details:

63. Is the condition due to Injury or Sickness arising out of the patient's employment? ○ Yes ○ No

If 'Yes', have you discussed Workers' Compensation with the patient? ○ Yes ○ No

64. Do you believe the patient will recover or is any Permanent Impairment likely? ○ Yes ○ No

If 'No', give details:

Signed: Date:

Please use validation stamp or complete in block capitals:

Doctor's Name:

Qualifications:

Practice/Clinic:

Address:

Telephone No: Fax Number:

Email:

Or Validation Stamp:

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This claim is administered by our Third-Party Administrator (TPA), ProClaim.

