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AFS Licence Number: 244330
ABN: 17 140 340 361

Personal Accident & Illness Claim

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

Policy Number		RIB Ref No	
Insured Name			
Claimant's Name:			
Address for Notices	Insurance Brokers | Financial Planners, Po Box 1098 Buddina QLD 4575		
Phone		Fax No.	
Date of Birth			
Occupation:			
Describe your usual duties:			
Height:	cm	Weight: kg	
Address			

Are you registered for GST? Yes ☐ No ☐ What is your ABN?

Are you entitled to claim an input tax credit on the GST component of the premium applicable to this Policy?	No ☐ Yes ☐ - Are you entitled to claim an amount less than 100%?	
	No ☐ Yes ☐ - specify amount claimed	%
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	No ☐ Yes ☐ - Are you entitled to claim an amount less than 100%?	
	No ☐ Yes ☐ - specify amount claimed	%

Injury/Illness Details

1. Give a full description below of injury or illness for which are you claiming

Illness	
Condition	
How did it commence?	
Injury:	
How were you Injured?	
What Injuries did you receive?	

What were you doing when you were injured?	
Where did the accident occur?	
Name of person who witnessed the accident	
Address of witness	
Telephone number of witness	
Did the injury occur during the course of your usual occupation	Yes ☐ No ☐
If the injury resulted from a motor vehicle accident were you required to undergo a breath analysis or blood test? If yes, attach a copy of the analysis result	Yes ☐ No ☐
2. Have you ever had this, or similar condition, in the past? If yes, give details	Yes ☐ No ☐
Condition:	
Treated by?	
Date	

3. Give the exact date when illness began, or injury occurred:	Date		Time	am/pm
4. When did you first consult a doctor for this condition?	Date		Time	am/pm
5. When did you become totally disabled? (unable to work)	Date		Time	am/pm
6. If still disabled, when do you expect to return to work?	Date		Time	am/pm

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

- One or more of the material tasks of your occupation?	Date	
- All of the tasks of your occupation?	Date	

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

Name of hospital	**Address**	**From**	**To**	**In/Outpatient**

9. Details of all attending physicians		
Doctor's name	**Address**	**Telephone number**

10. Who is your usual family doctor?				
Doctor's name	**Address**		**Telephone number**	
How long has ben been receiving treatment or advice from this doctor?		years		months

11. What other medical or surgical treatment has been received during the past 5 years?			
Date	**Nature of Treatment**	**Doctor's name**	**Address**

12. Are you now, or have you even been, subject to or affected by any other injury, disease, deformity, defect of senses, infirmity or weakness? If Yes, give details:	Yes ☐ No ☐
Details	
13. Have you ever lodged a personal accident or illness claim before? If Yes, give details	Yes ☐ No ☐
Details	

14. Are you making or entitled to make any other insurance or compensation claim in respect of this disability?			
Sick Leave	Yes ☐ No ☐	Motor Compensation	Yes ☐ No ☐
Other Government benefits	Yes ☐ No ☐	Workers' Compensation	Yes ☐ No ☐
Private health fund	Yes ☐ No ☐	Superannuation life insurance	Yes ☐ No ☐
Name of fund(s)/insurance company:			

15. Name of previous employers over last 5 years		
Name of employers	**Period: From**	**Period: To**

Important: Attached is an attending physician's statement for your doctor to complete. Your claim cannot be processed until we receive your completed claim together with the attending physicians statement We will also require medical certificates each month from the date of disablement and a final certificate showing the actual date you resumed work.

Declaration of Earnings

Important Information

1. If you are self-employed, Weekly Earnings means your weekly earnings derived from personal exertion after allowing for the cost and expenses n incurring that income. Please complete Section 1
2. If you are not self-employed, Weekly Earnings means your weekly remuneration earned from personal exertion by way of salary, fees, wages, commissions, and any other items already agreed by us. Please complete Section 2
3. You may be required to supply proof of your income by submitting copies of your personal and/or business income tax returns for the full financial year immediately preceding the injury or illness for which you are now claiming.

Section 1 – Self Employed Persons (to be completed by your accountant)

Business/Trading Name:					
Address		State		Postcode	
Was the business fully operational and was the Insured fully employed at the time of suffering the accident or contracting the illness?			No ☐ Yes ☐ - give details		
Does the business have a Workers' Compensation Insurance?			No ☐ Yes ☐		
Please state the current weekly earnings (see important information 1 above):			$		
Accountant's name:			Signature:		

Section 2 – Employed Persons (To be completed by Employer)

Business/Trading Name:					
Address		State		Postcode	
Please state the current weekly earnings (see important information 2 above):			$		

Is the insured person entitled to Workers' Compensation benefits?		No ☐ Yes ☐ - give details of payments	
		a. weekly rate	$
		b. monies paid to date	$
Declaration of Earnings (continued)			
Was the insured person in your employ at the time of suffering the injury to illness?		No ☐ Yes ☐	
Is the insured person entitled to receive sick leave?		number of days entitled	days
Has the insured person received any sick leave payments in respect of the injury or illness for which he/she is claiming?		No ☐ Yes ☐	
		number of days	days
Please advise the insured person's gross salary at the date of injury or illness:		$	
Officer's Name:		Position:	
Telephone Number:		Signature:	
		Date	

Privacy

We are committed to protecting your privacy. We use the information you provide to advise about and assist with your insurance needs. We provide your information to insurance companies and agents that provide insurance quotes and offer insurance terms to you or the companies that deal with your insurance claim (such as loss assessors and claims administrators). Your information may be given to an overseas insurer (like Lloyd's of London) if we are seeking insurance terms from an overseas insurer, or to reinsurers who are located overseas. We will try to tell you where those companies are located at the time of advising you. We do not trade, rent or sell your information.

If you don't provide us with full information, we can't properly advise you, seek insurance terms for you, or assist with claims and you could breach your duty of disclosure.

For more information about how to access the personal information we hold about you and how to have the information corrected and how to complain if you think we have breached the privacy laws, ask us for a copy of our Privacy Policy or visit our website.

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. 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.
3. 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.

4. **Medical Authority:** I authorise any hospital, physician or other person who attended me, to give the Insurer or its representatives any or all information with respect of any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

Date: Signature:

EFT Payment Details (Please complete this section if you require payment directly into your account)			
Account Name			
BSB:		Account Number	
Bank Name		Address:	
Email Address for payment notification:			

ATTENDING PHYSICIAN'S STATEMENT

Policy Number		Claim Number	

Important – your doctor must complete the attending physician's statement. Your claim cannot be processed until re receive your completed claim together with the attending physician's statement.

Any charge for this statement must be borne by the patient.

Please complete all sections

Patient's Details								
Patient's Name (Block letters)								
Address								
			State		Postcode			
Date of Birth		Height	cms	Weight	kgs	Sex	Male ☐ Female ☐	
Occupation								

History		
When did the patient first receive medical treatment?	Date	
Was there a previous history of this or a similar condition? - Advise when treatment was given	No ☐ Yes ☐	

Condition
Please give a complete diagnosis of this condition

If Injury				
When did the patient suffer the injury?	Date		Time	am/pm
What did the patient tell you were the circumstances surrounding the injury?				

If Illness				
When was the illness first contracted?	Date		Time	am/pm
When did the symptoms become evident?	Date		Time	am/pm

Degree of Disability				
When was the patient obliged to cease work?	Date		Time	am/pm
If the patient is still disabled, when will the patient be able to resume:				
- one or more of the material tasks of his/her occupation?	Date			
- all of the tasks of his/her occupation?	Date			
If the patient has recovered, when was the patient able to resume				
- one or more of the material tasks of his/her occupation?	Date			
- all of the tasks of his/her occupation?	Date			
A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK				

Treatment of Present Condition

When were you first consulted? Date	
When were you last consulted? Date	
How often has the patient consulted you?	times
Was the patient confined to hospital? No ☐ Yes ☐ - give details	

Name of Hospital	Address	Period of Confinement	
		From	To

What are the current subjective symptoms?	
Please give results of any objective findings	
X-rays	
Other tests	
What surgical procedures have been performed or are being contemplated?	
Is there any underlying condition affecting recovery from the current condition? -if Yes, advise nature of underlying condition and how it affects disability and recovery	No ☐ Yes ☐
Please advise names and addresses of other treating physicians	
Do you believe rehabilitation would benefit this patient?	No ☐ Yes ☐
Have you terminated treatment?	No ☐ Yes ☐ - advise date
What is the current prognosis?	
Are there any further remarks which may assist in assessing this condition?	

Doctor’s Name		Qualifications	
Address			
Telephone Number			
Signature		Date	