AusInsure

nationwide
insurance brokers pty ltd
AFSL 234535

Accident And/Or Sickness Claim Form

Please forward this completed form to:

Nationwide Insurance Brokers
Locked Bag 12
Castle Hill NSW 1765
Telephone: 02 9634 6600
Fax: 02 9634 6610

AusInsure Pty Ltd ABN 45 121 032 559 Authorised Representative AR Authority No. 339752
Of Nationwide Insurance Brokers Pty Ltd ABN 49 067 066 371
Underwritten by certain Underwriters at Lloyd's of London

Version: AusInsure 2009

COMPLETING YOUR CLAIM FORM

We wish to ensure that your claim is processed promptly.
To assist us can you please use this check list?

☐ Have you answered ALL questions for your section of the claim form is answered?

☐ That you have **signed and dated** the claim form.

☐ The Statement by your usual Doctor is completed.

☐ The Statement by your treating Doctor is also completed, (if different from your usual doctor) **OR** obtain copies of reports from the hospital, treating doctor that have provided to your usual Doctor.

☐ Employer/Principal Contractor Declaration is attached.

If your disablement is ongoing, a medical certificate must be provided every
TWO WEEKS.

The certificate must be mailed or faxed to us to make sure benefit payments are not delayed.

The medical certificate must state the REASON for your disablement.
For example the words "Medical Condition" cannot be accepted.

If you assist us we will ensure that:-

- You will be notified as soon as your claim has been received.
- Once all the paperwork is received an assessment of your claim will be provided within 5 working days.
- Upon acceptance of your claim Benefit payments are made 2 weeks in arrears thereafter.

PLEASE NOTE: ALL BENEFIT PAYMENTS ARE MADE GROSS, NO INCOME/PAYG TAX IS DEDUCTED FROM THESE PAYMENTS. IT IS YOUR RESPONSIBILITY TO REPORT THIS WHEN DECLARING YOUR ANNUAL TAX RETURN.

PLEASE RETURN YOUR CLAIM FORM (& ongoing Medical Certificates, if applicable) to:

Nationwide Insurance Brokers
Locked Bag 12
Castle Hill NSW 1765
Telephone: 02 9634 6600
Fax: 02 9634 6610
Email: nationwide@nationw.com.au

PERSONAL ACCIDENT & SICKNESS
CLAIM FORM

IMPORTANT INFORMATION

Please complete all questions and send this form to us to enable us to promptly process your claim. If there is insufficient space on this form to provide your answers, please attach a separate paper.

Your claim cannot be processed until:

- You have fully completed the claim form, signed the declaration and provided any supporting documentation that may be required;
- We receive medical statements about your condition if they are required;

We subscribe to the General Insurance Code of Practice that sets the standards of practice and service for the insurance industry. It is our aim to provide a quality service to you, our customer. In the event we do not achieve our aim and cannot resolve the matter with you, we have dispute resolution process that you can access. Full details appear in the policy document under Code of Practice.

PRIVACY STATEMENT

Lloyd's and its agents are bound by the obligations of the Privacy Act 1988 as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act) This sets out basic standards relating to the collection, use, disclosure and handling of personal information.

"Personal information" is essentially information or an opinion about a living individual whose identity is apparent or can reasonably be ascertained from the information or opinion.

Information will be obtained from individuals directly where possible. Sometimes it may be collected indirectly (e.g. from your representatives)

Only information necessary for the arrangement and administration of Lloyd's business by Lloyd's, its agents and their representatives will be collected. This includes information necessary to accept the risk, to assess a claim, to determine competitive and appropriate premiums, etc.

Lloyd's and its agents disclose personal information to third parties who they believe are necessary to assist them in doing the above. These parties will only use the personal information for the purposes we provided it to them for (or if required by law).

When you give Lloyd's and its agents personal information about other individuals, we rely on you to have made or make them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by Lloyd's by contacting: -
Fenton Green & Co, (03) 8325 3333

Section 1 – Claimant Details

Policy No:	
Full Name of Insured Person:	
Date of Birth:	
Home Address:	
Postcode:	
Employer/Principal Contractor's Name:	
Telephone Business:	
Telephone Home:	
Mobile:	**EMAIL:**

Section 2 – To be completed by Claimant

CLAIMS FOR INJURY / ILLNESS

Please state fully:-

What is the injury or illness?
If injury, how exactly did I occur?
When did the injury occur, or the illness begin or first manifest itself or when was it first
Diagnosed? **Date: / /**
Did the injury or illness cause you to stop work? No: Yes: If so -when / /
Have you returned to work full-time? No: Yes: If so -when / /
Have you returned to work part-time? No: Yes: - if Yes, what hours are you working? Days Hours
Details of your usual Duties:
Who is your usual family doctor?
Name:
Address:
Telephone Number:
When did you first get treatment from a medical practitioner for this condition?
Doctors Name:
Address:
Telephone Number:
When did you first see the medical practitioner? / /

During the 24 hours before the injury, did you drink any alcohol or take any drugs?
No: Yes:
State types and quantities:
Are you affected by any long tem or chronic disability? No: Yes: - give details –
OTHER INSURANCE / BENEFITS
Are you claiming insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, sports body or any income replacement. **No: Yes: - give details below:**
Name of organisation:
Name of Insurer & Telephone Number:
Type of cover:
Amount Claimed:

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 Pty. Ltd or its representatives 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 agree that a Photocopy of this authorisation shall be considered as effective as the original.	
Your Signature:	
Name – print	**Date:**

PAYEES BANK DETAILS

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

Bank: ____

Account Name(s): ____

BSB Number: __________ __________

Account Number: ______________________________

EMPLOYER PRINCIPAL CONTRACTOR STATEMENT

Claimant Name			
First day not at work			
Date of employment with the Company			
Gross Earnings averaged over the last 6 months prior to the date of disablement			
Is there a Workers' Compensation Claim lodged or to be lodged?			
If Yes, what is the Weekly Compensation			
(Please attach all WorkCover correspondence)			
What payments have been made during the period of disablement			
WorkCover	$	From / /	To / /
Normal Pay	$	From / /	To / /
What is the usual occupation of the claimant?			
Has the Claimant returned to work? If YES, on what date:			

Name of Company					
Contact Details	Address				
Suburb		State		Postcode	
Telephone Number		Email			
Signature					
Name					
Position					

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. – Doctors STATEMENT

Patient's Name:
Date of Birth:
Height:
Weight:
Please give full details of injury/illness:
Final diagnosis:
When did the patient first receive medical attention for this condition?
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:
Are you the patient's usual doctor? YES/NO
If NO, please give name and address of claimant's usual doctor:
On what date did incapacity commence?
Is patient still incapacitated? YES/NO
If YES when will patient be able to return to work?
If NO when did incapacity cease?
Was the patient hospitalised as a result of this condition? YES/NO
How many days was the patient hospitalised?
Is the condition due to injury or sickness arising out of the patient's employment? YES/NO
Signed:
Date:
Qualifications:
Please use validation stamp or complete in block capitals:-
Name:
Address:
Validation Stamp:
Telephone No: