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# Personal Accident and Sickness Claim Form

*The issue of this form is not an admission of liability*

This form must be fully completed in the sections applicable to your claim and signed and dated.

**Important Note**: Be sure to refer to the New Claim Check List and ensure you have provided all required supporting documentation including medical certificates, a Tax File Number declaration form and pay history report.

| **Section 1 – To be completed by Claimant** | |
|---|---|
| Name of Policyholder: | |
| Policy Number: | |
| Full name of Insured Person: | |
| Occupation: | Date of Birth: |
| Address: | |
| Post Code: | |
| Telephone: | |
| Email: | |

| **PAYEE'S BANK DETAILS**<br>*When the claim has been approved the payment will be credited direct to your Bank Account* | |
|---|---|
| Bank: | SWIFT Code<br>(for non-Australian banks) |
| Account Number | BSB Number: |
| Account Holder's Name: | |

**CLAIMS FOR INJURY / ILLNESS / DEATH**

*Please state fully. Attach a separate sheet if there is insufficient space*

a. What is the injury/illness? _____

_____

_____

b. If Injury, how exactly did it occur? _____

_____

_____

_____

_____

_____

c. When did the Injury occur? _____

d. If Illness, when did the Illness begin or first manifest itself? _____

e. And when was the Illness first diagnosed? _____

f. Did the injury or illness cause you to stop work? ☐ Yes ☐ No If so, when: _____

g. Have you returned to work full-time? ☐ Yes ☐ No If so, when: _____

h. Have you returned to work part-time? ☐ Yes ☐ No If so, when: _____

i. What hours are you working? Days: _____ Hours: _____

j. Describe your usual pre-Injury Duties: _____

_____

k. Who is your usual GP to family doctor? Name: _____ Centre: _____

Address: _____ Phone: _____

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

_____

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

_____

n. Date of first Consultation or Emergency Department visit? _____

Name of this Doctor or Hospital: _____

Address: _____ Phone: _____

o. Were you hospitalised for this condition? ☐ Yes ☐ No Name of hospital? _____

p. Detail all treatments/surgery performed: _____

_____

_____

_____

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

_____

_____

r. During the 24 hours before the injury, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

If Yes, state types and quantities: _____

_____

s. Have you ever suffered from the same or a similar complaint in the past? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

_____

t. Are you affected by any long term or chronic disability? ☐ Yes ☐ No

If Yes, please provide details: _____

_____

_____

## OTHER INSURANCE COVER / BENEFITS

a. Do you have Private Health Insurance? ☐ Yes ☐ No Name of Fund: _____

☐ Hospital Only ☐ Extras

b. 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)* ☐ Yes ☐ No

If Yes, please provide details: _____

_____

_____

c. Name of organisation/Insurer: _____

d. Name of Insurer & Contact Details: _____

e. Type of cover: _____

f. Claim Number: _____ Policy Number: _____

g. Amount Claimed/Claimable: _____

*Attach a copy of the claim acceptance letter, Benefit Statement, other correspondence*

h. Name of Superannuation Fund: _____

i. Please confirm you have checked whether you have any Income Protection Cover with your Fund: ☐ Yes ☐ No

## DECLARATION AND AUTHORISATION - COMPLETE FOR ALL CLAIMS

*To be completed by the claimant*

- **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 affect this claim.
- **I authorise** any hospital, physician or other person who has attended me or any other Insurer to furnish the claims managers, Proclaim, with any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, treatment, copies of all hospital or medical reports, information on other claims for the same Injury or Sickness or any other information necessary to complete the assessment of my claim on request.
- **I authorise** any travel agent or airline to furnish the claims managers, Proclaim, with any and all information with respect to the circumstances of the lodged claim or any other information necessary to complete the assessment of my claim on request.
- **I agree** that a Photocopy of this authorisation shall be considered as effective as the original.

Name: _____ Date: _____

Signature: _____

## SECTION 2 - EMPLOYER OR PRINCIPAL CONTRACTOR STATEMENT/VERIFICATION

*To be completed a representative of the Insured Company for all claims*

a. Claimant Name: _____

b. When did Claimant cease work due to this Injury/Sickness? _____

c. Date claimant was employed by the Company? _____

d. Gross Weekly Salary averaged over the last 12 months prior to the date of disablement? _____

e. Did the Injury occur at work? ☐ Yes ☐ No

If so when will/was the Workers' Compensation Claim lodged? _____

What is the Weekly Compensation? _____

f. What payments have been made to date during the period of disablement:

WorkCover $ From: _____ To: _____

Normal Pay $ From: _____ To: _____

Sick Pay $ From: _____ To: _____

g. Claimant's Job Title: _____

h. What are his/her usual duties? _____

_____

_____

i. Has the Claimant returned to work? ☐ Yes ☐ No

If so, when: _____

I, (*Company Representative name and title*):_____

Address: _____

Phone: _____ Email: _____

Confirm that (*Insured Person*): _____

Is an Employee of: _____

And is entitled to claim against the Company's Personal Accident & Sickness Policy, number: _____

Signature: _____ Date: _____

**Please ensure that the employee's pay report and all WorkCover correspondence (if applicable) are included with this form**

**SECTION 3 - DOCTOR'S STATEMENT**

*This section must be fully completed by the attending doctor. Any fee for completion of this section is the responsibility of the Insured Person*

a. Name: _____

b. Date of Birth: _____

c. Height: _____ Weight: _____

d. Date of Onset of Sickness / Date of Injury: _____

e. When did you first examine the patient? _____

f. Please give full details of circumstances of injury/onset of illness: _____

_____

_____

_____

_____

g. Please detail the patient's symptoms: _____

_____

_____

_____

h. What was your clinical diagnosis? _____

_____

_____

_____

i. If not with you, when did the patient first receive medical attention for this condition? _____

From whom: _____

j. 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: _____

_____

_____

_____

k. Are you the patient's usual doctor? ☐ Yes ☐ No

If NO, please give name and address of claimant's usual doctor: _____

_____

**DISABILITY**

a. On what date did incapacity commence? _____

b. Is the 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

c. I intend to review the patient on: _____

d. If the patient is no longer disabled, when did he/she return to work _____

e. Please detail any investigations and provide results: _____

_____

_____

_____

f. Any other comments/clinical findings? ☐ Yes ☐ No

_____

_____

g. Was the patient hospitalised as a result of this condition? ☐ Yes ☐ No

If Yes, which Hospital? _____

How many days was the patient hospitalised? _____ Dates: _____

h. Detail any Surgical Procedures performed or planned:

Procedure: _____

Date performed/to be performed: _____

Procedure: _____

Date performed/to be performed: _____

i. Have you referred the patient to any other Medical Practitioner? ☐ Yes ☐ No

If Yes, Name/s and Specialty: _____

_____

j. Detail any Treatment recommended i.e. physiotherapy: _____

_____

k. Is there any other injury, illness or condition impacting the patient's recovery from the claimed condition? ☐ Yes ☐ No

l. 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

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

Doctor's Name: _____ Qualifications: _____

Practice/Clinic: _____

Address: _____

Phone: _____ Email: _____

Signed: _____ Date: _____

Or Validation Stamp:

**CLAIM LODGEMENT DETAILS**

*Please forward claim details to Proclaim using one of the following options.*

*We recommend keeping a copy of all documentation sent to us*

- **Email** (preferred) ahclaims@proclaim.com.au
- **Fax:** 1300 858 329
- **Post***:* Locked Bag 32012 Collins St East VIC 8003

For any claim enquiries, Proclaim can be contacted on: **+61 (2) 9287 1302**

Policy and coverage queries should be directed to your Insurance Broker

**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 full details of our Privacy Policy please visit https://proclaim.com.au/proclaim-privacy-policy/