making relationships count

CLAIM FORM: PERSONAL ACCIDENT INSURANCE

THE ISSUE OF THIS FORM IS NOT AN ADMISSION OF LIABILITY

PLEASE ENSURE

- You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim.
- You have enclosed all requested information/documentation.
- You have signed this claim form.
- Your attending doctor fully completes the statement.
- ALL MEDICAL CERTIFICATES MUST STATE THE REASON FOR YOUR DISABLEMENT (e.g. "medical condition" cannot be accepted)

SECTION 1: TO BE COMPLETED BY THE CLAIMANT

Certificate/Policy No: _____

Name of Insured/Employer: _____

Claimant Given Name and Family Name: _____

Date of Birth: _____

Address of the Insured: _____

Suburb: _____ Postcode: _____

Occupation: _____

Telephone No.: _____ Mobile No.: _____

Email: _____

Do you consent to us communicating with you by email? Yes ☐ No ☐

SECTION 2: CLAIMS FOR INJURY / ILLNESS / DEATH

What is the injury or illness? _____

If injured, how exactly did it occur? _____

Do you consider your injury to have been caused by your work? Yes ☐ No ☐

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? Yes ☐ No ☐

If YES, please provide the following details: Date: _____ /_____ / _____

Are you a part time or casual employee? Yes ☐ No ☐

Have you returned to work full-time? Yes ☐ No ☐

If YES, please provide the following details: Date: _____ /_____ / _____

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

If YES, what hours are you working?

Days: _____ Hours: _____

Details of your usual pre-injury Duties: _____

_____

Are you currently on a claim for any injury or sickness not including this claim? Yes ☐ No ☐

If YES, please provide the following details: Date: _____ /_____ / _____

Who is your usual family doctor? _____

How long have you been treated by your 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? Date: _____ /_____ / _____

Were you hospitalised for this condition? Yes ☐ No ☐

If YES, please provide the following details: Date: _____ /_____ / _____ to _____ /_____ / _____

At which Hospital? _____

Detail surgery performed: _____

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

State Types and Quantities: _____

Have you ever suffered this injury/illness or a similar condition before? Yes ☐ No ☐

Give details: _____

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

Give details: _____

OTHER INSURANCE / BENEFITS:

Are you entitled to claim compensation from your Superannuation Fund or any insurance through your Superannuation Fund?
Yes ☐ No ☐

Member number: _____

Are you entitled to claim insurance or compensation from any other insurance company?
e.g. Workers Compensation, Traffic Accident Commission, sports body or any Income Replacement, Private Health Insurance?
Yes ☐ No ☐

Give details: _____

Name of organisation/Insurer: _____

Name of Insurer & Contact Details: _____

Type of Cover: _____

Claim Number: _____

Amount Claimed: _____

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

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 affect this claim. I understand that any false statement or information may lead to my claim being denied.
- I also understand and accept that until I provide all required information, consent and authorities DUAL will not be able to process my claim and will have no obligation to make any payment to me or on my behalf.
- **I authorise** any hospital, physician or other person who has attended me to furnish to DUAL and the claims manager of Fullerton Health Corporate Services (FHCS), or its representatives, any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical reports.
- I authorise any Insurer, organisation or body through which I am claiming similar benefits to furnish to DUAL and FHCS all information with respect to this Sickness or Injury to enable assessment of my claim.

Signature: _____ Name (Print): _____

Date: _____ /_____ / _____

BANK ACCOUNT DETAILS

Please complete the following:

Bank: _____

Account Name(s): _____

BSB Number: _____ - - - _____

Account Number: _____

SECTION 3: EMPLOYER OR PRINCIPAL CONTRACTOR STATEMENT

Claimant Name: _____

When did Claimant cease working for this Injury/Sickness? _____

Date: _____ /_____ / _____

Is the claimant currently off work on an unrelated claim? Yes ☐ No ☐

Date of employment with the Company: _____ /_____ / _____

Gross Weekly Salary averaged over the last 12 months prior to the date of disablement (Please attach pay report)

$ _____

Did the Injury occur at work? Yes ☐ No ☐

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

If YES, what is the Weekly Compensation? _____

(Please attach all WorkCover correspondence)

What payments have been made to date during the period of disablement?

WorkCover $ _____ From _____ /_____ / _____ To _____ /_____ / _____

Normal Pay $ _____ From _____ /_____ / _____ To _____ /_____ / _____

Sick Pay $ _____ From _____ /_____ / _____ To _____ /_____ / _____

What is the usual occupation of the claimant? _____

What are his/her usual duties? _____

_____

Has the Claimant returned to work? Yes ☐ No ☐

If YES, please provide the following details: 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 4: DOCTOR'S STATEMENT

Patient's Name: _____

Date of Birth: _____ /_____ / _____ Height: _____ Weight: _____

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

_____

Final diagnosis: _____

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

When did the patient first receive medical attention for this condition? _____

_____

Was the disability sports related? Yes ☐ No ☐

If YES, please provide details: _____

_____

Does the patient have any other injury or sickness that is contributing to the condition?

Yes ☐ No ☐

If YES, please provide details: _____

_____

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? _____

_____

_____

When did the patient first consult you for this condition? _____

How long have you been treating the patient? _____

On which date did incapacity commence? Date: _____ /_____ / _____

Is patient still incapacitated? Yes ☐ No ☐

If YES, please estimate when you expect the patient to be able to return to full time work or part time work?

Date: _____ /_____ / _____

Please advise on:

Working hours: _____ Capacity: _____

Restrictions: _____

If NO, when did incapacity cease?

Date: _____ /_____ / _____

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

How many days was the patient hospitalised?

_____ Days From _____ /_____ / _____ To _____ /_____ / _____

Detail any Surgical Procedures performed or planned: _____

_____

Detail any Treatment recommended i.e. physiotherapy: _____

_____

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: _____

Telephone No. _____ Fax No: _____

Email Address: _____

Validation Stamp: _____

SECTION 5: CLAIM LODGEMENT DETAILS

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

(Please keep a copy of all documents sent to FHCS)

By Post:

Fullerton Health Corporate Services

Level 10, 33 York Street

Sydney NSW 2000

Email Address:	Fax No:
claims@fullertonhealthcs.com.au	+61 2 8256 1775

Phone Number:

Once the claim form has been completed, sent, and received by FHCS, claim inquiries can be made to FHCS on:

+ 61 (2) 8256 1770

Policy and coverage queries should first be directed to your Insurance Broker.

PRIVACY STATEMENT:

At DUAL Australia Pty Ltd, we are committed to compliance with the Privacy Act 1988 (Cth). We use the personal information you provide in connection with a claim to assess, administer and manage the claim. If you don't provide us with full information, we may not be able to do this. When assessing a claim, we may need to collect information from people like your insurance broker, employer, medical and financial advisers and Government agencies. If you provide us with information about someone else you must obtain their consent to do so.

We provide your information to the insurer we represent when we assess and administer your claim. When providing insurance terms or assessing your claim, we will tell you if the insurer is overseas and if so, where they are. We are part of the Hyperion Insurance Group and may provide your information to UK based Group entities who provide us with business support services. We may also provide your information to third parties such as: (1) your insurance broker or other person who acts for you; (2) contracted third party providers who supply us with services such as claims investigation and management companies, legal and medical advisers and loss adjusters; and (3) Government agencies (where we are required to do so by law). We will take all reasonable steps to ensure that our service providers comply with the Privacy Act.

Our Privacy Policy contains information about how you can access the information we hold about you, ask us to correct it, or make a privacy related complaint. You can obtain a copy from our Privacy Officer by telephone (+61 (0)2 9248 6300), email (reception@dualaustralia.com.au) or by visiting our website (www.dualaustralia.com.au).

By signing this claim form, you consent to the collection and use of your personal information as outlined above and in our Privacy Policy.

Other Disclosures

Personal information may be disclosed to:

Brokers and agents who refer your business to us, your superannuation fund and any organisations appointed by them to administer your insurance related matter;

Any person acting on your behalf, including your financial adviser, solicitor or accountant, executor, administrator, trustee, guardian or attorney;

Your employer;

Medical practitioners (to verify or clarify, if necessary, any health information you may provide), claims investigations and reinsurers (so that any claim you make can be accessed and managed). Other insurers to which your insurance is transferred by your employer or superannuation fund;

Organisations, including overseas organisations, to whom we outsource certain functions.

In all circumstances where our contractors, agents and outsourced service providers become aware of personal information, confidentiality arrangements apply. Personal information may only be used by our agents, contractors and outsourced service providers for our purposes.

We may be allowed or obliged to disclose information by law, eg. Under Court Orders or Statutory Notices, pursuant to taxation or social security laws.

Your acknowledgment and consent

Your signature below indicates your consent to such use and disclosures of your personal information as are

indicated above.

Signature: _____ Name (Print): _____