

personal accident and sickness claim form



Wesfarmers General Insurance Limited, ABN 24 000 036 279, AFS Licence no. 241461

Level 1, 8 Gardner Close, Milton or PO Box 2212 Milton QLD 4064
Freecall 1300 651 654 Fax 07 3367 5105

IMPORTANT INFORMATION - Read before completing this form.

Please answer ALL relevant questions concerning your claim and make sure your Employer and Doctor complete ALL the relevant questions as well.

Failure to complete ALL the relevant questions will delay your claim. If a question is not applicable to you please write N/A or strike through the answer.

Please PRINT your answers and use a black or blue pen. Please tick boxes (✓) where applicable

NOTE: The issuing of this form is not an admission of liability

1. Claimant Details

Surname Given name(s)

Residential street address

Suburb State Postcode

Phone number Mobile number

Occupation

Describe your usual duties

Date of birth Sex Male Female Height cm Weight kg

Your Australian Tax File Number *Your Australian Tax File Number will be kept safe and secure and only used for tax related purposes. If you do not wish to provide your Tax File Number, we will then have to apply the highest applicable tax rate to any taxable benefits paid to you for this claim.*

Name of your employer (if applicable)

Address

Suburb State Postcode

Phone number

Are you registered for GST?
Yes No

If **Yes**, please enter the Australian Business Number (ABN) and Input Tax Credit (ITC) entitlement percentage below

ABN % entitlement to Input Tax Credits

If you fail to advise the availability of an Input Tax Credit or understate its availability, then you may have a liability to pay tax on the claim payment.

2. Details of the Accident causing Injury

Date of accident (dd/mm/yyyy)

Time of accident

 am/pm

Where did the accident occur?

Please give a FULL description of the accident and how you sustained your injury(ies):

Did the police attend the accident? Yes No If **Yes**, please give details below

Police station

Attending officer's name

Police case reference number (if given)

Were you under the influence of any drugs or alcohol at the time of the injury / accident?

Yes No

If **Yes**, please give details, including any readings that were taken (attach a copy of any reports to this claim form)

When did you first consult a doctor for your injury(ies)?

Date (dd/mm/yyyy)

Time

 am/pm

When did you first become unable to work from the injury(ies) you sustained in the accident?

Date (dd/mm/yyyy)

Time

 am/pm

If you are still disabled, when do you expect to return to work?

Date (dd/mm/yyyy)

Time

 am/pm

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

Name of hospital

Address

Date/Time admitted

 am/pm

Date/Time discharged

 am/pm

Inpatient or outpatient?

Please give details of all the doctors that attended you

Doctor's name	Address	Phone number

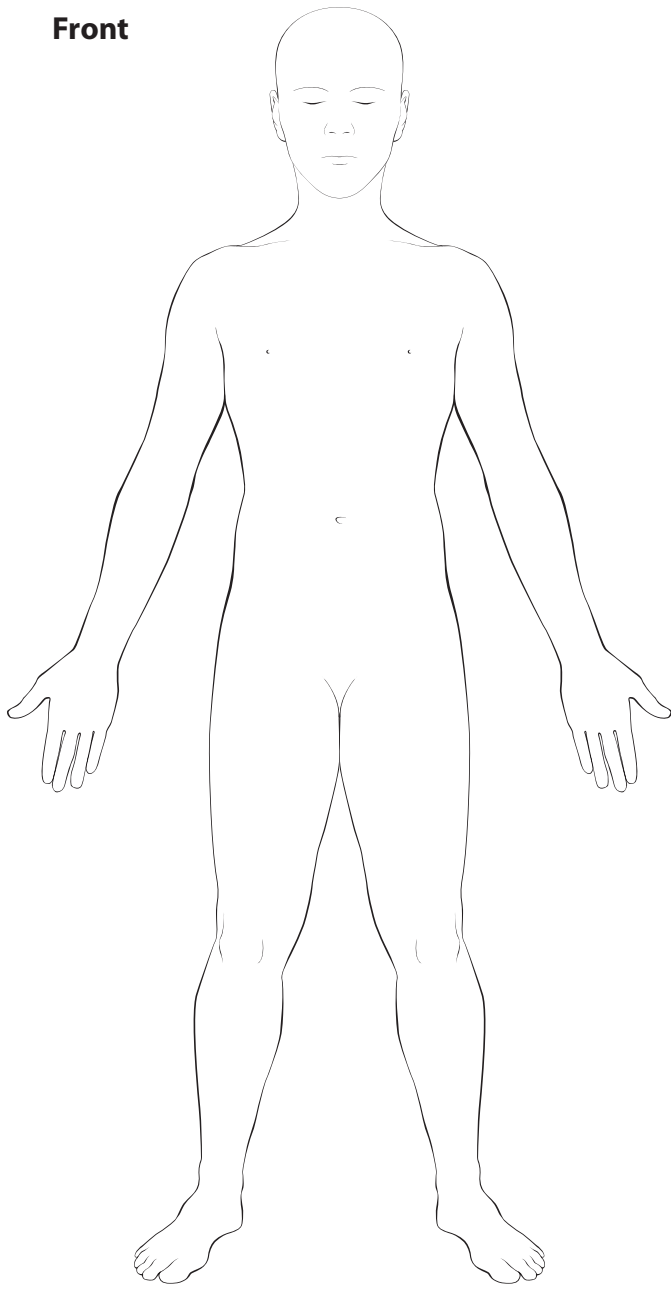
Have you ever had this or a similar condition in the past? Yes No

If **Yes**, please give details -

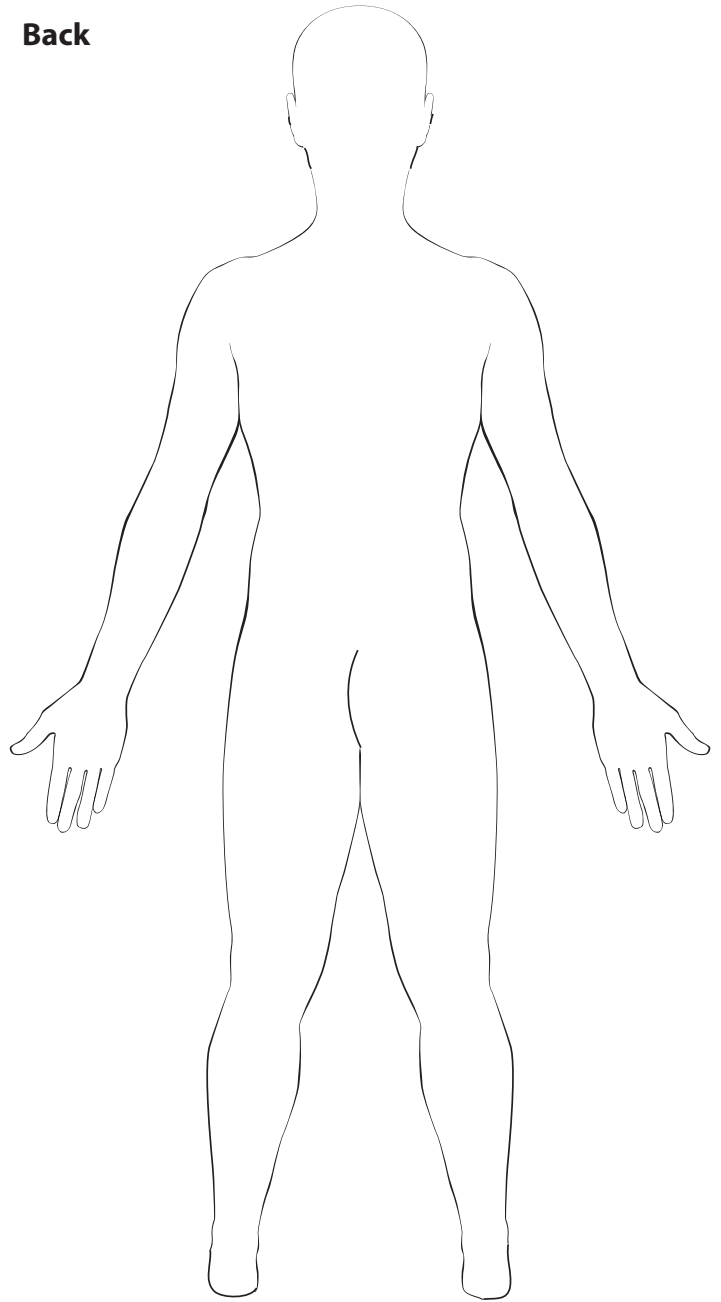
Condition	Treating doctor	Phone number	Date first treated

Please indicate the site of your injury(ies) on the diagram appropriate below.

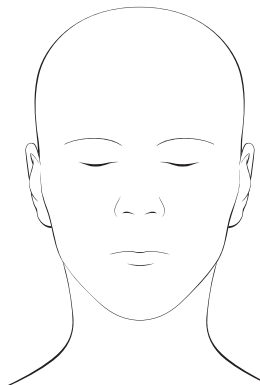
Front



Back



Head



3. Witnesses to the Accident

Please give details below of person(s) who witnessed the accident

1. Name				Phone number		
Address				State	Postcode	
2. Name				Phone number		
Address				State	Postcode	
3. Name				Phone number		
Address				State	Postcode	

4. Details of the Sickness

What sickness or condition are you suffering from?

When did you first become aware of the sickness or condition?

Date Time am/pm

What date did you first seek medical treatment for the sickness or condition?

Date Time am/pm

Have you suffered from the same or similar sickness or condition in the past?

Yes No

If **Yes**, please provide details below

Doctor's name and address

Phone number

Fax number

Dates of treatment

<input type="text"/>	<input type="text"/>	from	<input type="text"/>	to	<input type="text"/>
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On what date were you first unable to attend to the usual duties of your work?

Date Time am/pm

How long do you expect to be off work from this sickness or condition?

days/weeks

If you are still disabled, what date do you think you will be able to return to work?

Date

Have you been advised to cease treatment for this sickness or condition?

Yes No

What are the contact details of the treating doctor(s) you have consulted for this sickness or condition?

1. Doctor's name and address

Phone number

Fax number

Dates of treatment

<input type="text"/>	<input type="text"/>	from	<input type="text"/>	to	<input type="text"/>
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2. Doctor's name and address

Phone number

Fax number

Dates of treatment

<input type="text"/>	<input type="text"/>	from	<input type="text"/>	to	<input type="text"/>
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3. Doctor's name and address

Phone number

Fax number

Dates of treatment

<input type="text"/>	<input type="text"/>	from	<input type="text"/>	to	<input type="text"/>
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If there is not enough space, please attach a separate sheet.

What is the current treatment you are receiving for this sickness or condition? (medication, physio, surgery, hospitalisation, etc)

What duties of your usual occupation are you able to perform with this sickness or condition?

What duties of your usual occupation are you not able to perform with this sickness or condition?

Please list all the medical practitioners you have consulted for any condition in the last 5 years:

1. Doctor's name and address

Phone number

Fax number

Dates of treatment

from	to
------	----

2. Doctor's name and address

Phone number

Fax number

Dates of treatment

from	to
------	----

3. Doctor's name and address

Phone number

Fax number

Dates of treatment

from	to
------	----

If there is not enough space, please attach a separate sheet.

5. Other Insurance

Yes No

Do you have any other insurance policy that provides weekly benefits in the event of an injury or sickness?

<input type="checkbox"/>	<input type="checkbox"/>
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If **Yes**, please give name of insurance company

Do you have any other insurance policy that provides lump sum benefits in the event of an injury or sickness?

<input type="checkbox"/>	<input type="checkbox"/>
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If **Yes**, please give name of insurance company

Are you entitled to make a claim under any other insurance or compensation scheme in respect of your injury or sickness?

<input type="checkbox"/>	<input type="checkbox"/>
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If **Yes**, please give details of who you could claim from (workers compensation, transport accident authority, etc) and their contact details

Have you ever had an injury or sickness insurance claim before?

<input type="checkbox"/>	<input type="checkbox"/>
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If **Yes**, please provide details:

6. Earnings Declaration

IMPORTANT: You are required to supply proof of your earnings (please refer to the Policy Wording for the definition of "Earnings") to support your claim. You need to submit copies of your personal and/or business income tax returns for the full financial year immediately preceding the condition for which you are now claiming.

SELF EMPLOYED PERSONS ONLY TO COMPLETE THE FOLLOWING

Business/Trading name

Business address

State

Postcode

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Business phone number

Was the business fully operational and were you fully employed at the time of the accident or sickness? Yes No

If **No**, please provide details

Does your business have Workers Compensation insurance?

Yes No

Please state your current weekly Earnings

\$

Accountant's name

Phone number

EMPLOYED PERSONS ONLY – TO BE COMPLETED BY YOUR EMPLOYER

Employer's name

Phone number

Address

State

Postcode

Please state the employee's current weekly Earnings (*including allowances, bonuses, overtime, etc*)?

\$

What is the employee's **base** weekly Earnings (*excluding allowances, bonuses, overtime, etc*)?

\$

Is the employee entitled to Workers Compensation Benefits? Yes No

If **Yes**, please provide details of entitlement or any payments in (a), (b) and (c)

(a) Amount of weekly Earnings

\$

(b) Total Earnings paid to date

\$

(c) Date payments commenced

Was the employee employed by you on the date of the accident or sickness? Yes No

What were the employee's weekly Earnings at the date of accident or sickness?

\$

Please advise the number of days of accrued sick leave

days

This employee has been employed since

Your name

Your position at the company

Phone number

Signature

Date (dd/mm/yyyy)

Medical Authority and Declaration by Claimant

I hereby authorise any hospital, physician, insurer, health insurance commission, employer or other person who has attended me to supply Lumley Insurance or its representative with any and all information with respect to any injury or sickness, medical history, consultation, prescriptions or treatment, including copies of all my hospital and/or medical records. I agree that a photostat or facsimile copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said claim, make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims will be forfeited.

Name

Signature

Date (dd/mm/yyyy)

Privacy

The Privacy Act 1988 (as amended) seeks to ensure the confidentiality and security of any personal information. We are committed to ensuring that confidentiality and security.

The Lumley Insurance Privacy Policy detailing our handling of personal information is available on request. You may request access to information held by us about you, by contacting us. You may also access our Privacy statement on our website at www.lumley.com.au

7. Medical Practitioners Statement - to be completed by your Doctor

Patient's name

Patient's date of birth

Patient's sex

Male Female

Patient's height

 cm

Patient's weight

 kg

What is your diagnosis of the patient's condition?

Do you consider the patient's condition to be as a result of an injury or sickness? (please give reasons why)

What do you think caused the patient's condition?

What date did you first consult with the patient regarding this condition?

Date (dd/mm/yyyy)

Time

am/pm

To your knowledge, do you know what date the patient first obtained medical treatment or advice for treatment in relation to this condition?

Date (dd/mm/yyyy)

Has the patient ever suffered a similar condition, and if so does it relate to his/her present condition?

Has the patient told you they were under the influence of alcohol or drugs at the time of the injury?

Yes No

If **Yes**, was a blood alcohol or drug test taken?

Yes No

If **Yes**, what were the results?

How long has the patient attended your practice?

Years

Months

Not before

What treatment is the patient receiving for this condition?

Please provide any relevant medical history that will assist us with the patient's claim

What investigations have been made in determining a diagnosis for the patient's condition?

Are you the patient's regular treating doctor?

Yes No

If **No**, please advise name and number of the patient's regular treating doctor

Do you consider the patient to be wholly and continuously prevented from engaging in his/her usual occupation as a result of this condition? If **Yes**, please specify the period

Yes No

from:

to:

Do you consider the patient to be able to carry out a substantial part of his/her usual occupation as a result of this condition? If **Yes**, please specify the period

Yes No

from:

to:

On what date do you consider the patient will be able to return to work

Is the patient's condition related to an accident?

Yes No

If **No**, please explain why

Name

Qualifications

Phone number

Fax number

Email

Address

State

Postcode

Signature

Date (dd/mm/yyyy)