ZURICH

Because life changes.

Personal Accident and/or Illness

YOUR PRIVACY

Privacy laws, effective 21 December 2001, require us to make the following disclosures before collecting personal information about you after that date:

- We require personal information about You to assess Your Claim. We may disclose Your personal information *(other than sensitive information such as health information)* to Your adviser (and any licensee or broker he or she represents), to Our service providers (including loss adjusters and investigators) and Our business partners for this purpose;
- We may also disclose personal information including sensitive information about You such as health information to medical practitioners, other health professionals, reinsurers, legal representatives and other consultants. By signing this Claim Form, You consent to Us and those organisations and other professionals collecting and disclosing sensitive information about You;
- if You do not provide the requested information or consent to its collection and disclosure as described above, the assessment of Your Claim may be delayed or We may not pay the Claim;
- We may also disclose personal information about You as required or permitted by law;
- in most cases, on request, We will give You access to the personal information We hold about You;
- You may contact Us regarding your privacy concerns by telephone on 132 687, e-mail Us at Privacy.Officer@zurich.com.au or by writing to “The Privacy Officer” at Zurich Financial Services Australia Limited, P.O. Box 677, North Sydney, 2059. Please provide details of Your policy number/s and/or claim number where known.

Claim Form

Personal Accident and/or Illness

Claim Form

ALL RELEVANT SECTIONS ARE TO BE ANSWERED IN FULL. PLEASE PRINT YOUR ANSWERS

THE COMPANY DOES NOT ADMIT LIABILITY BY THE ISSUE OF THIS FORM.
IT IS ISSUED TO ENABLE THE INSURED TO LODGE A WRITTEN STATEMENT OF CLAIM.

Claim No. *(Office Use Only)*

Type of Insurance Cover

Branch

Policy No.

Due Date

Broker/Agent

Address

Full name of Insured - Mr/Mrs/Miss/Ms

Occupation

Address Postcode

What is your ABN What is your ITC% for this risk

Private Phone Business Phone

Policy No. Age Weight Height

Are you self employed? Yes ☐ No ☐ If "No", please provide name and address of your employer

Name

Address Postcode

Please indicate which of the following best describes your present occupation:-

☐ (a) Clerical Work only

☐ (b) Supervising Manual Work

☐ (c) Performing Manual Work

☐ (d) Combination of (b) & (c)

Accident Details

Date of Accident / / Time of Accident am/pm Date present incapacity commenced / /

Describe exactly how the accident occurred

Nature and extent of injuries

Have you ever sustained an injury of this type in the past? Yes ☐ No ☐

If "Yes", please provide details

Where did accident occur?

Did this accident occur at work, or on a journey to/from work? Yes ☐ No ☐

If "Yes", are you entitled to Workers' Compensation?

Did you consume any drug or intoxicating liquor during twelve hours prior to the accident? Yes ☐ No ☐

If "Yes", please provide specific details

Illness Details

When first contracted / / Nature of illness

How and where contracted

Have you ever sustained an illness of this type in the past? Yes ☐ No ☐

If "Yes", please provide details

State the date your present incapacity commenced / /

General Particulars

Can compensation be claimed from any other company or insurer? Yes ☐ No ☐

If "Yes", please provide Name and Address of such organisation

Postcode

Have you been able, since the accident happened, to attend in **ANY WAY** to your business or employment? Yes ☐ No ☐

If "Yes", please provide details

What are your average weekly earnings $ When did you first obtain medical attention? / /

Please provide Name and Address of Medical Attendant

Postcode

DECLARATION ON PAGE 3 TO BE SIGNED

CLM 00006 - 12/01 - PCUS-55B8VF-2001

Medical Statement Accident and/or Illness

To be furnished by the person claiming at his own expense

TO BE FORWARDED TO THE COMPANY WITHIN SEVEN DAYS
AFTER RECEIPT BY THE INSURED, FULLY COMPLETED BY A DULY REGISTERED MEDICAL PRACTITIONER.

Name of Claimant (Patient)

Address | Postcode

Occupation

Date accident happened or illness commenced and where

How caused

On what date did you first attend the Claimant in consequence of present injured/illness?

(If the injuries sustained to a hand or an arm, a foot or a leg, state whether it is the Right or Left).

Have you reason to suspect Claimant was not sober at the time of accident?

How long have you known the Insured?

Are you the Claimant's regular Medical Attendant? Yes ☐ No ☐

If "No", who is the regular medical attendant?

To your knowledge, was the Insured at the time of the accident/illness suffering from any disease or physical infirmity? Yes ☐ No ☐

If "Yes", please provide details

Give date of last visit by the Claimant / /

Is the Claimant's incapacity due solely and directly to the accident or illness stated, independently of any other cause? Yes ☐ No ☐

If "Yes", please provide details

Note: Temporary Total Disablement by Accident or Sickness means: that the **Patient is rendered totally unable** to engage in or attend to his usual profession, business or occupation.

Temporary Partial Disablement by Accident Only means: that the **Patient is rendered unable in material degree** to attend to or engage in his usual profession, business or occupation.

I Estimate the Claimant will be **Totally** disabled for:

weeks days

I Estimate the Claimant will be **Partially** disabled for:

weeks days

I HEREBY CERTIFY that the foregoing statements are to the best of my knowledge, information and belief, true and complete, and that I am firmly of the opinion that the stated periods of the patient's Total and/or Partial Disablement are due solely and directly to the cause or causes I have stated.

Name (Please Print)

Address | Postcode

Qualification

Signed | Date

Declaration

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 injury or sickness shall 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 or future injuries or sicknesses shall be forfeited.

I further agree that any Professional person, Medical Practitioner or Hospital Authority who has been or may hereafter be consulted by me relative to the injury or illness is hereby authorised and directed by me to divulge at any time to Zurich Australian Insurance Limited, their legal representatives or Loss Adjusters, any information or history they may have acquired with regard to any injury or illness.

Signature of Insured

Date

Certificate of Total Disablement

To be retained by Insured for Completion on Recovery or returned completed with claim form if recovery complete

This is to certify that I have examined Mr./Mrs./Miss/Ms

on / / In my opinion he/she is/was suffering from

He/she will be/was **totally** unfit for work from / / and up to and including / /

Signed

Date

Qualification

The exact illness/injury causing the disability/incapacity **must** be stated.

Certificate of Partial Disablement/Incapacity

This is to certify that I have examined Mr./Mrs./Miss/Ms

on / / In my opinion he/she is/was suffering from

He/she will be/was **partially** unfit for work from / / and up to and including / /

Signed

Date

Qualification

The exact illness/injury causing the disability/incapacity **must** be stated.