Claim Form

Personal Accident Insurance

The issue of this form is not an admission of liability

PLEASE ENSURE

- You complete Sections 1 - 5 in full and then submit this Claim Form to your employer to complete Section 6 and your doctor to complete Section 7.
- You have enclosed all requested information/documentation.
- You have signed this Claim Form.
- All Medical Certificates must state the reason for your disablement (e.g. 'medical condition' cannot be accepted).

Section 1 | Claimant Details

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 / Sickness / Death

What is the injury or sickness? _____

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 sickness begin or first manifest itself or when was it first diagnosed?

Date: _____ / _____ / _____

Did the injury or sickness 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/sickness or a similar condition before? Yes ☐ No ☐

Give details: _____

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

Give details: _____

Section 3 | 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 and Contact Details: _____

Type of Cover: _____

Claim Number: _____

Amount Claimed: _____

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

Section 4 | Bank Account Details

Please complete the following:

Bank: _____

Account Name(s): _____

BSB Number: _____ - - - _____

Account Number: _____

Section 5 | Declaration

Claim Lodgement Details

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

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

Postal Address:
Corporate Services Network
GPO Box 4276
Sydney, NSW 2001

Email Address:
claims@csnet.com.au

Fax No:
+61 2 8256 1775

Phone Number:
Once the claim form has been completed, sent, and received by CSN, claim inquiries can be made to CSN on:
+61 (2) 8256 1770
Policy and coverage queries should first be directed to your Insurance Broker.

Privacy Collection Statement:

We are committed to protecting your privacy and complying with the *Privacy Act 1988* (Cth) ('Privacy Act').

We use your information to assess the risk of providing you with insurance, provide quotations, issue policies and assess and manage claims, on behalf of the insurers we represent. If you do not provide us with full information, we may not be able to provide insurance or assess and manage a claim. If you provide us with information about someone else, you must obtain their consent to do so.

We may provide your personal information to the insurer we represent, insurance regulators and other insurance bodies as required by law. We may also provide your information to your broker and any third party claims service providers (such as claims management companies, parties repairing or replacing the subject matter, loss adjusters and appointed law firms (and the like)). If a recipient is not regulated by laws which protect your information in a way that is similar to the Privacy Act, we will take reasonable steps to ensure that they protect your information in the same way we do or seek your consent before disclosing your information to them. We do not trade, rent or sell your information.

Our Privacy Policy contains more information about how to access and correct the information we hold about you and how to make a privacy related complaint, including how we will deal with it. By providing us with your personal information, you consent

to its collection and use as outlined above and in our Privacy Policy. Ask us for a copy of our Privacy Policy via email at privacy@dualaustralia.com.au or access it via our website using the following link.

Declaration and Authorisation Complete for all Claims

- I declare that the information in 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 to me to furnish to DUAL and the claims manager, Corporate Services Network (CSN), 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 CSN all information with respect to this Sickness or Injury to enable assessment of my claim.
- I declare that should any information provided in this form alter after the date of this declaration, I will give immediate notice thereof to CSN.
- I agree that CSN and the Underwriters may use and disclose my personal information in accordance with the 'Privacy Collection Statement' at the end of this Claims Form.
- I agree that a photocopy of this declaration shall be considered as effective as the original.

Signature: _____ Name (Print): _____

Date: _____ / _____ / _____

Section 6 | 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: _____

Employer's Signature

Signature: _____

Name: _____

Position: _____

Section 7 | Doctor's Statement

THIS SECTION MUST BE FULLY COMPLETED BY ATTENDING DOCTOR - ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON

Patient's Name: _____

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

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

_____

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 ☐

Doctor's Signature

Signed: _____

Date: _____ / _____ /_____

Qualifications: _____

Please use validation stamp or complete in block capitals: _____

Name: _____

Address: _____

Telephone No. _____ Fax No: _____

Email Address: _____

Validation Stamp: _____

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.