Accident/illness claim

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Hints and tips about completing your claim form

This should only take about 10 - 15 mins. We want to settle your claim for you as quickly as we can. If insufficient information is provided this may delay determination of liability on your claim.

How can I check the progress of my claim?

Please contact QBE Accident & Health Claims Team on 02 9375 4874 or accidentandhealth@qbe.com and advise the claim number you received from the acknowledgement notification.

What you need to do:

1. **Complete Insured & Claimant Details.** Insured is the name of the Policy Holder, Claimant is the person making the claim
2. **Complete Injury or Illness details –** depending on the medical condition
3. **DECLARATION OF EARNINGS:**
   a. **If you are Self Employed:** Your Accountant fully completes and sign this section, and you must also attach copies of your Profit & Loss Statements or tax returns for the full financial year immediately preceding your disablement
   b. **If you are Employed:** Your Employer fully completes and sign this section. Attach a copy of your most recent Payslip.
4. Sign and date boxes 1 and 2 in the Declaration and Authorisation section on Page 5
5. **Your Doctor** must complete in full the Attending Physician's Statement
6. Scan and email the claim form through to **accidentandhealth@qbe.com**

WE CANNOT PROCEED WITH THE CLAIM WITHOUT THIS INFORMATION.

Return the completed form to your Financial Services Provider or mail to QBE Insurance, GPO Box 4108, Sydney NSW 2001 or **accidentandhealth@QBE.com**

Accident/illness claim

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Return the completed form to your Financial Services Provider or mail to QBE Insurance, GPO Box 4108, Sydney NSW 2001 or accidentandhealth@QBE.com

Policy No. ______ **Claim No.** ______

Insured Details

Insured's name					
Claimant's name					
Are you registered for GST?	No Yes	What is your ABN?			
Are you entitled to claim an input tax credit on the GST component of the premium applicable to this Policy?	No Yes	- Are you entitled to claim an amount less than 100%?			
	No Yes	- Specify amount claimed	%		
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	No Yes	- Are you entitled to claim an amount less than 100%?			
	No Yes	- Specify amount claimed	%		
Address					
	Suburb		State		Postcode
Contact Numbers	Home		Work		
	Mobile		Email		
Date of Birth (dd/mm/yyyy)		Height cm	Weight kg	Sex	Male Female
Occupation		Describe your usual duties			

Injury Details

Give a full description below of injury or illness for which you are claiming.					
1. Date of Accident		Time:		AM PM	
2. Were there any witnesses	No Yes				
3. Details of person who witnessed the accident?	Name		Telephone		
	Address				
		Suburb		State	Postcode
4. How were you injured?					
5. What injuries did you receive?					
6. What were you doing when you were injured?					
7. Where did the accident occur?	Street		Suburb		
	Nearest cross street				
8. Have you previously been treated for a similar or same injury?	No Yes	If Yes, give details.			

Injury Details (continued)

9. Provide details of any previous injury against any insurance company No Yes If Yes, give details.
(Please attach separate sheet if insufficient)

a) Are you making or entitled to make any other insurance or compensation claim in respect of this disability?

Sick leave	No	Yes	Motor compensation	No	Yes	Other government benefits	No	Yes
Workers' compensation	No	Yes	Private health fund	No	Yes	Superannuation life insurance	No	Yes

Name of fund(s)/insurance company

Name of previous employers over last 5 years	Period *(dd/mm/yyyy)*	
	From	To

IMPORTANT: Attached is an attending physician's statement for your doctor to complete. Your claim cannot be processed until we receive your completed claim together with the attending physicians statement. We will also require medical certificates each month from the date of disablement and a final certificate showing the actual date you resumed work.

10. During the 24 hours before the injury, did you drink any alcohol or take any drugs? No Yes If Yes, give details.

Illness Details

1. Have you ever had this or a similar condition, in the past? No Yes If Yes, give details.

Condition					
Treated by		Date			
2. Give the exact date when illness began, or injury occurred.		Date		Time	am/pm
3. When did you first consult a doctor for this condition?		Date		Time	am/pm

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

Name of hospital	Address	From	To	In/Out patient

Capacity to Work

5. When did you become totally disabled (unable to work)?	Date		Time	am/pm
6. If still disabled, when do you expect to return to work?	Date		Time	am/pm

7. If you have returned to work, when were you able to again perform:

• one or more of the material tasks of your occupation?	Date	
• all the tasks of your occupation?	Date	

Medical History and Other Insurance

8. Details of all attending physicians.

Doctor's name	Address	Telephone number

9. Who is your usual family doctor?

Doctor's name	Address	Telephone number

How long have you been receiving treatment or advice from this doctor? years months

10. What other medical or surgical treatment has been received during the past 5 years?

Date	Nature of treatment	Doctor's name	Address

11. Are you now, or have you ever been, subject to or affected by any other injury, disease, deformity, defect of senses, infirmity or weakness? No Yes If Yes, give details.

12. Provide details of any previous illness against any insurance company No Yes If Yes, give details.
(Please attach separate sheet if insufficient)

13. Are you or entitled to make any other insurance or compensation claim in respect of this disability?

Sick leave	No	Yes	Motor compensation	No	Yes	Other government benefits	No	Yes
Workers' compensation	No	Yes	Private health fund	No	Yes	Superannuation life insurance	No	Yes

Name of fund(s)/insurance company

Name of previous employers over last 5 years	Period *(dd/mm/yyyy)*	
	From	To

IMPORTANT: Attached is an attending physician's statement for your doctor to complete. Your claim cannot be processed until we receive your completed claim together with the attending physicians statement. We will also require medical certificates each month from the date of disablement and a final certificate showing the actual date you resumed work.

Payment Methods (Please note we are not liable for any bank processing fees on the receiver side)

Australian bank account	Provide details below	Deposit slip provided	
Bank name		Account name	
BSB		Account number	

Declaration of Earnings

IMPORTANT INFORMATION

1. **If you are self-employed, Weekly Earnings means your weekly earnings derived from personal exertion after allowing for the cost and expenses in incurring that income. Please complete Section 1 and attach a copy of your Profit & Loss Statements or most recent Individual Tax Return.**
2. **If you are not self-employed, Weekly Earnings means your weekly remuneration earned from personal exertion by way of salary, fees, wages, commissions and any other items already agreed by us. Please complete Section 2.**
3. **If You work more than one job, You may be required to supply proof of your income for ALL employments by submitting copies of your personal and/or business income tax returns for the full financial year immediately preceding the injury or illness for which you are now claiming.**

SECTION 1 – SELF EMPLOYED PERSONS (To be completed by your accountant).

Business/Trading name					
Address					
		State		Postcode	
Was the business fully operational and was the Insured fully employed at the time of suffering the accident or contracting the illness?	No Yes – if Yes give details				
Does the business have Workers' Compensation Insurance?	No Yes				
Please state the current weekly earnings (see Important Information 1 above).					$
Accountant's name		Signature			

SECTION 2 – EMPLOYED PERSONS (To be completed by your Employer).

Business /Trading Name					
Address					
		State		Postcode	
Date Employment Commenced *(dd/mm/yyyy)*					
Please state the current weekly earnings (see Important Information 2 above).					$
Is the insured person entitled to Workers' Compensation benefits?	No Yes – give details of payments				
				a) Weekly rate	$
				b) Monies paid to date	$
Was the insured person in your employ at the time of suffering the injury or illness?	No Yes				
Is the insured person entitled to receive sick leave?	No Yes			number of days entitled	days
Has the insured person received any sick leave payments in respect of the injury or illness for which he/she is claiming?	No Yes			number of days	days
Please advise the insured person's gross salary at the date of injury or illness.	$				
Officer's Details					
Name		Position			
Telephone number		Signature		Date	

Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our **Privacy Policy** at **www.qbe.com.au/privacy**, or to obtain a copy by phoning us on **133 723** or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Declaration and Authorisation

The information and answers given above are true, correct and complete in every detail.

1. I/we understand the claim may be refused if information is not true or is withheld.
2. I/we authorise QBE to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Medical Authority: I authorise any hospital, physician or other person who attended me, to give QBE or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

A photocopy of this authorisation will be considered as effective and valid as the original.

Signature of Insured 1. ______ Date *(dd/mm/yyyy)* ______

Signature of Insured 2. ______ Date *(dd/mm/yyyy)* ______

Attending physician's statement

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Policy Number		**Claim Number**	

Important - your doctor must complete the attending physician's statement. Your claim cannot be processed until we receive your completed claim together with the attending physician's statement.

Any charge for this statement must be borne by the patient. Please complete all sections.

Patient's Details

Patient's name (block letters)								
Address								
	Suburb			State		Postcode		
Date of Birth		Height	cm	Weight	kgs	Sex	Male	Female
Occupation								

Diagnosis (if any fracture or dislocation, describe nature and location i.e. Simple, Compound)

Cause				
Is this condition	an injury	or	an Illness	

Does the patient have any other injury or illness that is contributing to the condition?	No	Yes	If Yes, give details
Is condition due to injury or sickness out of the patient's employment?	No	Yes	If Yes, give details
Was the disability sports related?	No	Yes	If Yes, give details

Date of onset/first symptoms?	
When did the patient first consult you for this condition?	

Has the patient ever had the same or similiar condition?	No	Yes	If Yes, give details

Date of onset/first symptoms?		Diagnosis	
Name of patient's usual doctor/medical practice			
How long have you been the patient's usual doctor/medical practice?			
If the patient has been hospitalised please provide; Admission date		Discharge Date	
Hospital name			

Patient's Details (continued)

Has the patient had surgery or is it anticipated?			No	Yes	If Yes, give details
Date performed or anticipated		Hospital name			
Given name of hospital					

Please outline all treatment received to date in the management of your patient's condition.
Please include any relevant medical documents, reports or investigation scans.

Was the patient referred by you or to you?			No	Yes	If Yes, give details
Date of referral					
Doctors details	Name		Telephone		
Address					
	Suburb		State		Post code	

Is the patient still disabled?

No	When did the patient return to work?		Yes	How long will the patient be;	
				totally disabled (unable to perform any part of their occupation)	**partially disabled** (able to perform part of their occupation)
			From		From
			To		To

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body? No Yes

Name of Company			
Contact		Claim Number	
Signature of medical practitioner		Date	
Name (Print)		Qualifications	
Address			
	Suburb	State		Postcode	
Telephone			