ACCIDENT CLAIM REPORT

Accident and Health

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. ***Please answer all questions to avoid delays with your claim.***
2. When completing this form please print.
3. The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Ltd.
4. Only original doctor's certificates will be accepted.
5. Accident & Health International Underwriting Pty Ltd is an agent for Allianz Australia Insurance Limited who is a signatory to the General Insurance Code of Practice developed by the Insurance Council of Australia.
6. If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd staff you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your complaint within fifteen (15) working days.

   If you are not happy with our answer, or we have taken more than fifteen (15) working days to respond, you may take your complaint to the General Insurance Enquiries and Complaints Scheme (IEC), an external dispute resolution body; IEC also has a Claims Review Panel which will adjudicate on claims.

   Access to the Dispute Resolution process is free of charge to you. In addition, although Allianz Australia Insurance Limited is bound by the panel's decision, you are not and you have a right to pursue the matter elsewhere if you wish.

   We will provide the contact telephone number and address of your local IEC office upon request.

POLICY NO: | **EXPIRY DATE:**

Name of Insured Person _____
Surname Given Names

Residential Address _____

_____ State _____ Postcode _____

Telephone No. Home _____ Business _____

Occupation, Trade or Profession _____

Date of Birth _____ Weight _____ Height _____

Please tick preferred form of payment for refund Cheque ☐ Direct Payment ☐ If you have selected Cheque please nominate payee _____

If you have selected Direct Payment please supply the following information (alternatively supply a deposit slip noting the following information)

Bank _____ Account Name _____

Branch Number _____ Account Number _____

ACCIDENT

Address where accident occurred; _____

Time: _____ am/pm Date: _____

Were there any witnesses to the Accident? Yes ☐ No ☐

Witness Name: _____

Witness Address: _____

Exactly How did the Accident happen? _____

_____

What were the injuries? _____

Have you been treated for any serious previous injury? Yes ☐ No ☐

If Yes, please give details: _____

Give details of any previous claim made for any previous injury against any insurance company: (please attach separate sheet if insufficient space)

Period of Insurance (from / to)	Company Name	Company Address

Please continue over page →

Accident & Health International Underwriting Pty Limited
ABN 26 053 335 952
Level 32, 60 Margaret Street, Sydney, NSW 2000, Australia
GPO Box 4213, Sydney, NSW, 2001, Australia. Phone +61 2 9251 8700 Fax +61 2 9251 8755 Freecall: 1800 618 700 Freefax: 1800 618 755
Level 46, South Rialto Tower, 525 Collins Street, Melbourne, VIC, 3000. Phone +61 3 9614 6116 Fax +61 3 9614 5153
Email: enquiries@acchealth.com.au Web Site: www.acchealth.com.au

TREATMENT

Was hospital treatment required? Yes ☐ No ☐
If Yes, please complete the following (please attach separate sheet if insufficient space)

Hospital Stay			
From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

When did you stop work? Time _____ am/pm Date _____

When did you first obtain treatment from doctor? Time _____ am/pm Date _____

Name of Doctor _____

Address _____

Is this doctor still treating you for the injury? Yes ☐ No ☐

Is this doctor your regular doctor? Yes ☐ No ☐
If No, please give details

Regular Doctor's Name _____

Address _____

Is there any condition (past or present) affecting your current disability? Yes ☐ No ☐

If Yes, please give details _____

Are you now:

Recovered ☐ When did you return to work? ___/___/___

Partially Disabled ☐ When did you begin to do part of your normal activities? ___/___/___

Totally Disabled ☐ When do you expect to return to work? ___/___/___

Have you made, or will you make, a claim for benefits under any Workers' Compensation Act or Ordinance because of this injury? Yes ☐ No ☐
If Yes, please give details

Name Address

Employer _____

Workers Comp. Insurer _____

Claim Number (if known) _____

Are you entitled to claim benefits for this illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? Yes ☐ No ☐
If Yes, please give details:

Name Address

_____

_____

DECLARATION

1. All the information that I/We have given in this claim form is true and complete.
2. I/We authorise you to ask My/Our medical practitioner or any person/company/organisation for information that you need to act on this claim.
3. I/We are willing to provide further details to Accident & Health, or an assessor regarding my claim as may be required.

Date ___/___/___ Signature of the Policyholder _____

Date ___/___/___ Signature of the injured person (Complete only if not the Policyholder) _____

EMPLOYMENT

1. ***IF SELF EMPLOYED***

Confirmation of earnings MUST be submitted with claim form (eg. Income Tax Return)

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

2. ***IF EMPLOYED AS A WAGE EARNER TO BE COMPLETED BY YOUR EMPLOYER***

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an Injury suffered whilst _____ on the ___/___/___

He/She has been incapacitated since ___/___/___ and is expected to/did resume duties on ___/___/___

His/Her Gross Salary at the Date of Injury was _____ p.w.

During the period of incapacity he/she received:

$ _____	Normal Pay	from	___/___/___	to	___/___/___
$ _____	Sick Pay	from	___/___/___	to	___/___/___
$ _____	Workers' Compensation	from	___/___/___	to	___/___/___
$ _____	Other (Please specify)	from	___/___/___	to	___/___/___

Has been employed since ___/___/___

Name of Company _____

Address _____

Signature of Supervisor or Paymaster _____ Name (Please Print) _____

Telephone Number _____ Date ___/___/___

ATTENDING PHYSICIANS STATEMENT

THE INSURED IS RESPONSIBLE FOR COMPLETION OF THIS FORM WITHOUT EXPENSE TO THE COMPANY

Patient's Name _____

Patient's Address _____

What is disabling patient? _____

Please give a complete diagnosis of this condition _____

_____

HISTORY

1. When did the patient first receive medical treatment? _____

2. a) Is there a previous history of this or a similar condition? Yes ☐ No ☐

   b) If Yes, please state condition and advise when previous treatment was given _____

   _____

3. a) How long have you known the patient? _____

   b) Are you the regular general practitioner? _____

   If not, please advise who is _____

INJURY

1. When did the patient first suffer the injury? _____

2. What was the cause of the injury? _____

DEGREE OF DISABILITY

1. Patient's Occupation? _____

2. When was patient obliged to cease work? _____

3. If patient is still disabled, when approximately will the patient be able to resume:

a) Some duties? _____ **OR** b) Full duties? _____

4. If the patient has recovered, when was patient able to resume:

a) Some duties? _____ **OR** b) Full duties? _____

TREATMENT OF PRESENT CONDITION

When were you consulted? a) Initially _____ b) Most recently _____

How often has patient consulted you? _____

Was patient confined to hospital? Yes ☐ No ☐

If Yes, please advise Name and Address of hospital _____

Period of confinement From _____ To _____

What are the current subjective symptoms _____

Please give results of any objective findings (If insufficient space, please attach separate sheet)

1. X-Rays _____

2. Other Tests – Please advise tests done and findings? _____

3. What surgical procedures have been performed? _____

4. What surgical procedures are contemplated? _____

Are there any underlying conditions affecting recovery from the current conditions? Yes ☐ No ☐

If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery

_____

Has the patient any other physical or mental impairment? Yes ☐ No ☐

If Yes, please describe _____

Please advise names and addresses of other treating physicians.

_____

If you have terminated treatment, please advise date _____

What is the current prognosis? _____

Are there any further remarks which may assist in assessing this condition? _____

_____

Is there any permanent disability at present? Yes ☐ No ☐

If Yes, please explain estimated percentage of loss of function _____

Date _____ Signature _____ Qualification _____

Name (Please print) _____ Address _____

City or Town _____ State _____ Telephone _____