



ACCIDENT & HEALTH INTERNATIONAL

Claim Form

PERSONAL ACCIDENT &/OR SICKNESS

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. Please note that Sections 1, 2, 5, 7 & 8 are compulsory.
3. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Limited.

SECTION ONE: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

| | | | | | |
|-------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------------------|--|
| Policy Number | Expiry Date | | | | |
| <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | | | | |
| Name of Insurance Broker (if known) | | Name of Insured Company | | | |
| <input style="width: 100%;" type="text"/> | | <input style="width: 100%;" type="text"/> | | | |
| Title | Given Name(s) | | | Gender | |
| <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | | | <input type="checkbox"/> M <input type="checkbox"/> F | |
| Family Name | | | Date of Birth | | |
| <input style="width: 100%;" type="text"/> | | | <input style="width: 100%;" type="text"/> | | |
| Residential Address | Suburb | State | Postcode | | |
| <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | | |
| Email Address | Daytime Contact Number | | Alternative Number | | |
| <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | | <input style="width: 100%;" type="text"/> | | |
| Occupation, Trade or Profession | Usual Duties | | | | |
| <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | | | | |

SECTION TWO: PAYMENT DETAILS - COMPULSORY

Please tick preferred method of Payment for refund.

| | | | |
|-------------------------------------------|-------------------------------------------|-------------------------------------------|-------------------------------------------|
| <input type="checkbox"/> | Cheque | Payee | |
| | | <input style="width: 100%;" type="text"/> | |
| <input type="checkbox"/> | Direct/EFT Payment | Account Holder's Name | |
| | | <input style="width: 100%;" type="text"/> | |
| BSB Number | (6-Digits) | Account Number | Bank |
| <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> | <input style="width: 100%;" type="text"/> |

SECTION THREE: DETAILS OF ACCIDENT - COMPLETE IF AS A RESULT OF AN ACCIDENT

Date of Accident

Time

AM / PM

Address where accident occurred:

Were there any witnesses to the accident?

Yes No

Witness Name:

Witness Address:

Please describe how the accident / injury occurred:

What were the injuries?

Have you previously been treated for any serious 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)

SECTION FOUR: TO BE COMPLETED IF DISABILITY IS AS A RESULT OF AN ILLNESS / SICKNESS

The nature of illness:

When did the illness begin?

Have you had this complaint before?

Yes No

If Yes, how long were you disabled?

Days Months Years

SECTION FIVE: TREATMENT - COMPULSORY

Was hospital treatment required? Yes No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

| 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

When did you first obtain treatment from doctor? Time AM / PM

Name of Doctor Address

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

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

Name of Regular Doctor Address

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

If Yes, please give details

Are you now:

Recovered Yes No When did you return to work?

Partially Disabled Yes No When did you return to work undertaking part of

Totally Disabled Yes No 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 Transportation Act because of this injury? Yes No

If Yes, please give details

| | Claim Number (if known) | Name | Address |
|-----------------------------------------|-------------------------|------|---------|
| Employer | | | |
| Workers Comp / Transport Insurer | | | |

Are you entitled to claim benefits for this Injury / Illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? Yes No

If Yes, please give details

| Name | Address |
|------|---------|
| | |
| | |

SECTION SIX: TO BE COMPLETED ONLY IF CLAIMING FOR LOSS OF INCOME

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

1. IF SELF EMPLOYED PLEASE INDICATE BY TICKING THE BOX

Confirmation of earnings **MUST** be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

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 / Illness suffered whilst on the
He/She has been incapacitated since and is expected to/did resume duties on
His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was \$ per week.
During the period of incapacity he/she received: \$ from to
Please specify type of pay

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

Name of Company Has been employed since

Address

Signature of Supervisor or Paymaster Date

Name (Please Print) Telephone Number

SECTION SEVEN: DECLARATION - COMPULSORY

Dispute Resolution Statement

Accident & Health International Underwriting Pty Ltd is an agent for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.
If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd, 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 concerns within fifteen (15) working days.
If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme.
Access to the Dispute Resolution scheme is free of charge to you.

By signing and dating the form above or returning this form electronically, once completed, you declare the following:

Declaration:
I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We agree that, by submitting this form, the personal information I/We provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in our [Privacy Policy](#) including for the processing of this claim.

Authority
I authorise any hospital and/or physician who has treated me to provide Accident & Health International with copies of medical records or of my past medical history, as requested.

Signature of Claimant

Date

Signature of the Insured (if other than claimant)

Date

ACCIDENT & HEALTH INTERNATIONAL

MEDICAL CERTIFICATE

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 F: +61 2 9252 4385

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 AFS Licence No: 238621

Email:
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THE CLAIMANT MUST OBTAIN AT OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES

IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRES

SECTION EIGHT: PATIENT DETAILS - COMPULSORY

Full Name Date of Birth

Please give complete diagnosis of this condition

HISTORY

When did the patient first receive medical treatment?

Is there a previous history of this or a similar condition? Yes No

If Yes, please provide details

How long have you known the patient? Days Months Years

Are you the regular general practitioner? Yes No If not, please advise who is

SICKNESS

When was sickness first contracted?

When did symptoms become evident?

INJURY

When did the patient first suffer the injury?

OR

What was the cause of the injury?

DEGREE OF DISABILITY

When was patient obliged to cease work?
 Date

When was / will the patient be / able to return to:
 Some Duties?
 Full Duties?

TREATMENT OF PRESENT CONDITION

When were you consulted? Initially Most recently

Was patient confined to hospital? Yes No
 From To

If Yes, please advise name and address of hospital

What other surgical or medical procedures are possibly 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

What is the current prognosis?

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

Print Name: Qualification: Signature:
 Address: Phone:
 Fax: Date: