Personal Accident and Sickness Claim Form

The issue of this form is not an admission of liability

THANK YOU FOR NOTIFYING US OF YOUR CLAIM

PLEASE ENSURE

- ***You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim.***
- ***You have enclosed all requested information/documentation.***
- ***You have signed this claim form.***
- ***Your attending doctor fully completes the statement.***
- ***ALL MEDICAL CERTIFICATES MUST STATE THE REASON FOR YOUR DISABLEMENT (e.g. "medical condition" cannot be accepted)***

Section 1 – To be completed by Claimant

Certificate/Policy No:	
Full Name of Insured Person:	
Date of Birth:	
Full Address:	
Suburb:	**Postcode:**
Employers Name:	**Occupation:**
Telephone Business:	
Telephone Home:	
Mobile:	**EMAIL:**

Section 2 – To be completed by Claimant

CLAIMS FOR INJURY / ILLNESS / DEATH

Please state fully:-

What is the injury or illness?
If injury, how exactly did I occur?
When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed? Date: / /
Did the injury or illness cause you to stop work? No: Yes: If so -when / /
Have you returned to work full-time? No: Yes: If so -when / /
Have you returned to work part-time? No: Yes: If so -when / /
If Yes, what hours are you working? Days Hours
Details of your usual pre-Injury Duties:
Who is your usual 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? / /
Were you hospitalised for this condition? If yes, when: / / to / /
At which Hospital:
Detail surgery performed:
During the 24 hours before the injury, did you drink any alcohol or take any drugs?
No: Yes:
State types and quantities:
Have you ever suffered this Injury/Illness or a similar condition before? No: Yes: - give details –
Are you affected by any long tem or chronic disability? No: Yes: - give details –

OTHER INSURANCE / BENEFITS
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? No: Yes: - give details below:
Name of organisation/Insurer:
Name of Insurer & Contact Details:
Type of cover:
Claim Number:
Amount Claimed:
Attach a copy of the claim acceptance letter, Benefit Statement, other correspondence

DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS
I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.
I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim Pty. Ltd or its representatives any and all information with respect to any Sickness or Injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports.
I authorise any Insurer, organisation or body through which I am claiming similar benefits to furnish Proclaim with all information with respect to this Sickness or Injury to enable assessment of my claim.
I agree that a Photocopy of this authorisation shall be considered as effective as the original.
Your Signature:
Name – print **Date:**

PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.
Please complete the following:

Bank: _____

Account Name(s): _____

BSB Number: ___ ____ ___ --- ___ ____ ___

Account Number: _____

EMPLOYER OR PRINCIPAL CONTRACTOR STATEMENT

Claimant Name					
When did Claimant cease working for this Injury/Sickness?				/ /	
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? If so when will/was the Workers' Compensation Claim lodged?				/ /	
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? If YES, on what date:					
Name of Company					
Contact Details	Address				
Suburb		State		Postcode	
Telephone Number		Email			
Signature					
Name					
Position					

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

Section 3. – DOCTOR'S STATEMENT

Patient's Name:
Date of Birth:
Height: Weight:
Please give full details of circumstances of injury/onset of illness:
Final diagnosis:
Date of Onset of Sickness / Date of Injury: / /
When did the patient first receive medical attention for this condition?
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:
On what date did incapacity commence? / /
Is patient still incapacitated? YES/NO
If YES please estimate when you expect the patient to be able to return to work? / /
If NO when did incapacity cease? / /
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
Signed:
Date:
Qualifications:
Please use validation stamp or complete in block capitals:-
Name:
Address:
Telephone No: Validation Stamp: