

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. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
3. The issue of this form is not an admission of liability.
4. Once completed please either email or mail the claim form to Fullerton Health Corporate Services.

SECTION 1: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

Employer name	Policy Number		
<input type="text"/>	<input type="text"/>		
Title	Given Name(s)	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	
Family Name	Date of Birth		
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Residential Address	Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Do you consent to us communicating with you by email?	Y <input type="checkbox"/> N <input type="checkbox"/>	Email Address (important)	
		<input type="text"/>	
	Daytime Contact Number	Alternative Number	
	<input type="text"/>	<input type="text"/>	
Occupation, Trade or Profession	Work Site / Location		
<input type="text"/>	<input type="text"/>		
For what are you claiming?	<input type="checkbox"/> Weekly Benefit	<input type="checkbox"/> Capital Benefit	<input type="checkbox"/> Death

SECTION 2: EFT AUTHORISATION

Please tick preferred method of Payment for refund.

I hereby authorise and request that Fullerton Health Corporate Services credit my bank account as indicated below:

<input type="checkbox"/> Direct/EFT Payment	Account Holders Name			
	<input type="text"/>			
	BSB Number	(6-Digits)	Account Number	Bank
	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>
<input type="checkbox"/> Cheque	Payee			
	<input type="text"/>			

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

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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

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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 6: TO COMPLETED BY PERSON MAKING A CLAIM FOR DEATH BENEFIT

Name of Person Completing the Form:

Telephone Number:

Email address:

Company Name (If applicable) and Address:

Relationship with deceased – tick box below:

Employer Next of kin Executor Family Doctor Lawyer Other

If next of kin, state relationship:

THE FOLLOWING DOCUMENTS MUST BE INCLUDED WITH THIS CLAIM:

- Certified copy Death Certificate.
- Certified copy of Original Birth Certificate
- Copy of the Coroner's Depositions & Findings (if applicable).

Was a coronial inquest held or is one being held? Yes No

If so give details below:

Privacy Notice

Liberty International Underwriters (LIU) and Fullerton Health Corporate Services (FHCS) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information.

LIU collects personal information in order to provide insurance services and products and for ancillary business purposes and FHCS collects personal information in order to provide claim assessments and insurance related services. LIU and FHCS may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, UK, Singapore, Hong Kong and Malaysia.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from LIU and FHCS. If you do not provide the personal information LIU, FHCS or other relevant third parties require to offer you specific products or services, LIU or FHCS may not be able to provide the appropriate type or level of service.

If you wish to gain access to or correct your personal information, make a privacy complaint, or if you have any query about how LIU or FHCS collects or handles your personal information please write to LIU's Privacy Officer at privacy.officer.ap@libertyiu.com or call +61 2 8298 5800 and/or FHCS's Privacy Officer at privacy@csnet.com.au or call +612 8256 1770..

To obtain a copy of LIU's Privacy Policy go to LIU's website (www.liuaustralia.com.au) or request a copy from LIU's Privacy Officer.. To obtain a copy of FHCS's Privacy Policy go to FHCS's website (www.fullertonhealthcs.com.au) or request a copy from FHCS's Privacy Officer.

When you give LIU or FHCS personal or sensitive information about other individuals, LIU and FHCS rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, neither FHCS or LIU have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to FHCS or LIU using and disclosing my personal information pursuant to their Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to FHCS's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to FHCS or LIU such personal information (including health information) as FHCS or LIU in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to FHCS in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, FHCS or LIU may not be able to process or assess my claim.

I appoint FHCS to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant:

Date: | |

Name of Claimant:

Signature of Witness (any adult person):

Date: | |

Name of Witness:

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

Employers Name:

This is to Certify that: has been unable to attend his/her occupation as a result of Injury or Sickness

From: Until:

His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was: AUD \$:

Has your Employees last 12 months payroll history been attached with this report, and if not please provide Yes No

His / Her sick leave entitlement as at the date of injury or illness. Days:

He/She has been employed since Date:

Please confirm if he/she are still an Employee Yes No

Please confirm date they were no longer employed Date:

Has a claim for Worker's Compensation been lodged Yes No

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission/CTP? Yes No

SIGNATURE OF SUPERVISOR or MANAGER:

NAME OF SUPERVISOR or MANAGER:
(PLEASE PRINT)

TELEPHONE NUMBER:

DATED:

The claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly

Patients Name

DOB:

Height:

Weight:

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

Cause:

Is this condition an injury an illness

Does the patient have any other injury or illness that is contributing to the condition? Yes No

Provide Details

Is condition due to injury or sickness arising out of the patient's employment? Yes No

Provide Details

Was the disability sports related? Yes No

Provide Details

Date of onset/first symptoms?

When did the patient first consult you for this condition?

Has the patient ever had the same or similar condition? Yes No

From when & diagnosis:

Name of patient's usual doctor/medical practice:

How long have you been the patient's usual doctor/medical practice?

If the patient been hospitalized please provide; Admission Date Discharge Date

Name of Hospital

