

Personal Accident / Sickness

Claim Form



PLEASE RETURN COMPLETED FORM TO YOUR JLT OFFICE:

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Personal Accident/Sickness Claim Form

IMPORTANT

We act upon your claim as soon as we receive this form. You can help us in the assessment of your claim, if you:

1. Complete this form in full. Supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents as indicated may result in a delay in processing your claim.
2. Provide a comprehensive description of the circumstances of the accident / injury or the sickness.
3. If this claim form does not provide enough space, please use a separate piece of paper and attach as supplementary information.
4. When all information has been completed, please forward the claim form to **Jardine Lloyd Thompson Pty Ltd.**

PERSONAL STATEMENT			
Claimant Name	<input type="text"/>		
Postal Address	<input type="text"/>		
	<input type="text"/>	Postcode	<input type="text"/>
Telephone No	<input type="text"/>	Mobile No.	<input type="text"/>
E-mail address:	<input type="text"/>	Facsimile No.	<input type="text"/>
Date of Birth	<input type="text"/>	Height	<input type="text"/>
		Weight	<input type="text"/>
Occupation	<input type="text"/>		
Employer's Name	<input type="text"/>	Telephone No	<input type="text"/>
Location / Department	<input type="text"/>		
Gross weekly salary / income (before tax)	\$ <input type="text"/>	Please refer to Page 7	

FOLLOWING CLAIM ACCEPTANCE BY YOUR INSURER, PLEASE ADVISE PREFERRED METHOD OF PAYMENT			
Cheque	<input type="checkbox"/>	Direct Payment	<input type="checkbox"/>
		If you selected Cheque, nominate payee <input type="text"/>	
If you have selected Direct Payment please supply the following information (alternatively supply a deposit slip noting the following information)			
Bank	<input type="text"/>	Account Name	<input type="text"/>
Branch Number	<input type="text"/>	Account Number	<input type="text"/>

SUMMARY OF CLAIM											
I am claiming the following benefits under this insurance											
Lump Sum Benefits	<input type="text"/>	Amount	\$ <input type="text"/>								
Weekly Benefits	<table border="1"> <tr> <td>From Date</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> <td>To Date</td> <td><input type="text"/></td> <td><input type="text"/></td> <td><input type="text"/></td> </tr> </table>	From Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	To Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	Amount	\$ <input type="text"/>
From Date	<input type="text"/>	<input type="text"/>	<input type="text"/>	To Date	<input type="text"/>	<input type="text"/>	<input type="text"/>				
Other (please specify)	<input type="text"/>	Amount	\$ <input type="text"/>								

STATEMENT OF CLAIM (To be completed by the claimant)			
1.	When did the accident occur or when did you first become aware of your sickness?		
	Date	<input type="text"/>	Time <input type="text"/> am / pm
2.	What is the date of the first day you were unable to work? <input type="text"/>		
3.	What medical practitioner(s) did you consult?		
	Name	<input type="text"/>	Date of visit <input type="text"/>
	Name	<input type="text"/>	Date of visit <input type="text"/>

STATEMENT OF CLAIM (To be completed by the claimant)

4. What is the name and address of your usual doctor? (family General Practitioner)

	Telephone	

5. In your own words, please describe the injury or sickness

6. Please describe exactly what you were doing at the time of your injury or sickness and how it happened

7. Where did the injury or sickness occur?

--

8. Please state when you first became aware of symptoms before consulting your GP or Specialist

--

If your condition is a result of an accident, state whether the accident happened at work, in a road accident or whilst travelling to or from work or other

9. Were Police in attendance as a result of this accident?

YES

NO

If yes, please provide a copy of their report or the attending officer's name and Police Station

--

10. Please provide names and addresses of any witnesses

11. Was hospitalisation required?

YES

NO

If yes, name of Hospital

--

Dates confined

--

12. Was the use of an ambulance required?

YES

NO

13. Have you ever suffered from this or a similar condition in the past?

YES

NO

If yes, please provide details and dates

14. During the 24 hours before the injury, did you consume alcohol or drugs?

YES

NO

If yes, please state types and quantities

STATEMENT OF CLAIM (To be completed by the claimant)

15. Are you making, or are you entitled to make a claim in respect of this injury or sickness for any of the following?

- | | | | | | |
|-----------------------|------------------------------|-----------------------------|---------------------------|------------------------------|-----------------------------|
| Sick Leave | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Centrelink Benefits | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Third Party Insurance | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Worker's Compensation | YES <input type="checkbox"/> | NO <input type="checkbox"/> |
| Other Insurance | YES <input type="checkbox"/> | NO <input type="checkbox"/> | Other Government Benefits | YES <input type="checkbox"/> | NO <input type="checkbox"/> |

If yes, please provide details (and dates where applicable)

16. Name of your Superrannuation Fund and Member Number

17. When did you, or when do you expect to resume work?

Please provide your reasons explaining why you are unable to carry out your usual duties

18. Do you consider yourself fit for alternative duties? YES NO

If yes, have you discussed the possibility with your employer and if so what was the outcome?

19. Have you engaged in any other income earning employment since you became disabled? YES NO

If yes, please provide details

20. Have you ever made a previous claim in respect to Accident or Sickness Insurance? YES NO

If yes, please provide details

CLAIMANT DECLARATIONS & MEDICAL AUTHORISATIONS

I

solemnly and sincerely DECLARE that the information given by me in this claim is true and complete.

I UNDERSTAND that the claim may be declined if the information supplied is untrue or I have not revealed all relevant facts.

I AGREE to supply any further information that may be requested of me in connection with my claim.

I AUTHORISE any Doctor, Dentist, Physiotherapist, Company, Firm or person to disclose to **Beazley Underwriting Pty Ltd** any and all information that they may request in connection with this claim

My Medicare Number

I AGREE that a photocopy of this Authorisation shall be considered to be effective and valid as the original
I have read and accept the **Privacy Statement** provided with this claim form

Signature of Claimant

Date:

INCOME DETAILS (DELETE 1 OR 2, WHICHEVER IS NOT APPLICABLE)

1. IF SELF EMPLOYED

If the claimant is not an employee (i.e. a **self employed** contractor) then the gross weekly income derived from personal exertion in their usual occupation, after deducting any expenses necessarily incurred in deriving that income, averaged over the number of weeks so engaged during the twelve (12) months immediately preceding the date disablement giving rise to claim, must be supplied.

Your Accountant's Name

Address

Phone No

Please confirm employment / position status (i.e. Director/Partner/Sole Trader)

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

I hereby certify that

has been unable to attend their usual occupation with the company as a result of an injury/injuries or sickness suffered on

- a. What was the employee's last day at work?
- b. When is the employee expected to / did resume duties?
- c. If the claimant is an Employee, please complete the attached **Declaration of Pre-Disability Earnings Form** to confirm earnings across the number of weeks so engaged during the fourteen (14) weeks immediately preceding the date of disablement giving rise to this claim.
- d. When did the claimant commence employment with the Company?
- e. Please describe the claimant's usual occupation
- f. Has the employee lodged or intend lodging a **Worker's Compensation Claim**? YES NO

If yes, please provide copy confirmation of acceptance or rejection (letter) from the Insurer

- g. Is there any additional information you would like to provide in relation to the submission of this claim?

Name of Company

Postal Address

Signature of Supervisor or Paymaster Date

Name of Supervisor or Paymaster

Telephone No. Fax No. E-mail

DECLARATION OF PRE-DISABILITY EARNINGS

WEEKLY EARNINGS DURING THE 14 WEEKS PRIOR TO INCAPACITY -for employees

Worker's Name

PLEASE READ THE FOLLOWING DEFINITION OF "ORDINARY TIME EARNINGS" BEFORE COMPLETING THIS FORM

"Ordinary Time Earnings" means the actual ordinary hourly rate of pay the employee receives for ordinary hours of work including, but not limited to, superannuation and redundancy fund allowance, tool allowance, industry allowance, trade allowances, shift loading, special rates, qualification allowances (e.g. first aid, laser safety officer), multi-storey allowance, site allowance, asbestos eradication allowance, leading hand allowances, in charge of plant allowance, supervisory allowances and all other allowances applicable. Ordinary Time Earnings includes the base hourly rate of pay as set out in Schedule 2 of the EBA plus all-purpose allowances and any regular over Award payments as well as casual rates and any additional rates and allowances paid for work undertaken during ordinary hours of work, including fares and travel.

	Week Ending DD/MM/YY	Gross Weekly Earnings As Noted Above Plus Overtime If Applicable
1	<input type="text"/>	\$ <input type="text"/>
2	<input type="text"/>	\$ <input type="text"/>
3	<input type="text"/>	\$ <input type="text"/>
4	<input type="text"/>	\$ <input type="text"/>
5	<input type="text"/>	\$ <input type="text"/>
6	<input type="text"/>	\$ <input type="text"/>
7	<input type="text"/>	\$ <input type="text"/>
8	<input type="text"/>	\$ <input type="text"/>
9	<input type="text"/>	\$ <input type="text"/>
10	<input type="text"/>	\$ <input type="text"/>
11	<input type="text"/>	\$ <input type="text"/>
12	<input type="text"/>	\$ <input type="text"/>
13	<input type="text"/>	\$ <input type="text"/>
14	<input type="text"/>	\$ <input type="text"/>
	Total	\$ <input type="text"/>
	Average Weekly	\$ <input type="text"/>

Earnings during the fourteen (14) weeks prior to disablement must be provided. (Please note if cover is provided on a site specific basis, then only the earnings in relation to that site should be provided.)

To avoid delays, please ensure that this form is fully completed with ALL "Ordinary Time Earnings" as detailed in definition above. Please note the Weekly Benefit entitlements will be calculated upon the information/declaration that you provide.

I sincerely DECLARE that to the best of my knowledge the information provided above is true, accurate and complete.

Payroll Officer's Name

Payroll Officer's Signature Date:

DOCTORS STATEMENT (PLEASE PRINT LEGIBLY – THIS FORM CANNOT BE ACCEPTED OTHERWISE)

IMPORTANT

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist).
3. Dashes or blank spaces are not acceptable
4. **If the regular or usual doctor was not the treating doctor, this statement will also have to be completed by the claimant's regular doctor. If the claimant has been referred to another physician for treatment, a subsequent statement may be required to be completed by that physician.**

Claimant's Full Name

1 How many years or months has the Claimant been your patient / under your care?

2

a) What date were you first consulted by the Claimant in connection with the present condition?

b) How long had the patient been experiencing symptoms prior to consulting you for the first time?

c) Are these symptoms consistent with the current diagnosis?

d) When do you believe this condition first manifested?

3

a) What is the exact nature of the present sickness or injury?

b) If X-Ray examination or other tests have been made, state finding and/or quote report

c) What is the (proximate) cause of the disabling condition?

4

a) Is the current condition in any way related to their work? YES NO

b) Would you support a Worker's Compensation claim? YES NO

Please explain why or why not?

5 Has the patient previously suffered from the same or a similar condition? YES NO

a) Date of consultations

b) What was the diagnosis?

c) Was this occurrence / recurrence expected? YES NO

If yes, please explain why

d) Do you expect any further recurrence of this condition? YES NO

If yes, please explain why

6 Is there anything in the patient's medical history that may have contributed or aggravated, either directly or indirectly to the injury / sickness? YES NO

If yes, please provide details

7 Is there anything in the patient's medical history that may be likely to delay the recovery? YES NO

If yes, please provide details and advise how long recovery may be delayed.

8 Please provide summary details of all past and present medical advice and treatment provided to the patient in respect of his / her current disablement.

9 Do you consider treatment other than that being received is essential to recovery? YES NO

If yes, please provide details. How might this promote a return to work?

10 Have you referred the patient to other specialist services or treatment? YES NO

If yes, please provide details and a telephone contact number.

11 If the Claimant has already been hospitalised, please give name of hospital and dates.

12 Is treatment likely to be prolonged by any complications? YES NO

If yes, please provide details and advise how long treatment may be prolonged.

13 Has the Claimant continued to follow medical advice? YES NO

If no, please provide details

14 Is there any reason or evidence to suggest the patient was under the influence of intoxicants at the time of the accident or that intoxicants may have caused the injury? YES NO

15

a) When was the Claimant obliged to cease work?

b) When did or when do you realistically expect the Claimant to resume work?

i) Full unrestricted duties?

ii) Modified duties, if necessary?

iii) Normal duties in reduced capacity (i.e. restricted hours)

If unable, to return to work in a partial capacity, please provide an explanation

16 I hereby certify that the patient has been and/or will be totally disabled from carrying out his / her usual occupation or duties as follows:

From To (Inclusive)

Additional remarks: (e.g. Prognoses, life expectancy, occupational rehabilitation, surgery waiting list)

Doctor's Name

Doctor's Address

Telephone No. Fax No

I hereby certify that I have personally examined the above-named Claimant and that in my opinion the statements made in the Statement of Claim section of this Claim Form are consistent with the Claimant's injury or sickness.

I have read and accept the **Privacy Statement** provided with this Claim Form

Signature Date

Qualifications

Collection Statement Under Privacy Act 1988

JARDINE LLOYD THOMPSON PTY LTD
ABN 69 009 098 864

In accordance with the Privacy Act 1988 (and subsequent amendments), we, Jardine Lloyd Thompson Pty Ltd (and our subsidiaries and related entities) (JLT) draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other JLT products or services. If you are proposing for or renewing insurance, the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909 or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and JLT related Group companies.
- By providing the information requested in the attached document, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement.
- If you do not provide all or part of the information requested, we may be unable to process your application or provide other required services, your application for insurance may be declined or you may prejudice your insurance cover.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided, as they occur.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's consent.
- Our Privacy Policy can be made available on request or can be accessed on our website (www.jlta.com.au)
- For further information contact your account executive or the JLT Privacy Officer:

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