Personal Accident and Sickness Claim Form

The issue of this form is not an admission of liability

PLEASE ENSURE

- ***You fully complete every question before your doctor completes their statement. Failure to do so will result in delay in handling your claim.***
- ***You have enclosed all relevant supporting documentation including x-ray & other scan reports, a completed Tax File Number Declaration and proof of pre-Disability income.***
- ***You have signed the Declaration and Authority on this claim form.***
- ***Your attending doctor has fully completed the Medical 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:	
Policy Holder/Insured:	
Full Name of Insured Person:	
Date of Birth:	/ /
Full Address:	
Suburb:	**Postcode:**
Occupation:	
Telephone Business hrs:	**Mobile:**
Telephone Home:	
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 it occur?					
When did the *Injury* occur?	**Date:** / /		**Time:**		AM
Or when did the Illness begin or first manifest itself?		**Date:** / /			
And when was the Illness first diagnosed?		**Date:** / /			
Did the injury or illness cause you to stop work?	Yes	**If so -when** / /			

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Have you returned to work full-time? Yes	**If so -when** / /
Have you returned to work part-time? Yes	**If so -when** / /
If Yes, what hours are you working?	**Days** **Hours**
Describe your usual pre-Injury Duties:	
Who is your usual GP to family doctor?	
Name:	
Clinic/Medical Centre:	
Address:	
Telephone Number:	
When did you first see your usual doctor for this condition? / /	
When did you first get treatment from any medical practitioner for this condition?	
Date of first Consultation or Emergency Department visit? / /	
Name of this Doctor or Hospital:	
Address:	
Telephone Number:	
Were you hospitalised for this condition? Yes	**If yes, when:** / / **to** / /
At which Hospital:	
Detail all surgery performed:	
What other treatment have you had or has been recommended?	
During the 24 hours before the injury, did you drink any alcohol or take any drugs? Yes	
State types and quantities:	
Have you ever suffered this Injury/Illness or a similar condition before? Yes	**- give details –**
Are you affected by any long tem or chronic disability? Yes	**- give details –**

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OTHER INSURANCE / BENEFITS
Do you have Private Health Insurance? Yes ☐ **Hospital Only** ☐ **Extras** ☐
Are you *entitled* to, and/or have you now made, or intend to make, a claim for benefits of any type in regard to this Injury or Sickness? This includes Workers' Compensation, Traffic Accident Commission, CTP, sports association policy and any Income Protection Policy including those taken out through your Superannuation Fund:-
No: ☐ **Yes:** ☐ **- give details below:**
Name of organisation/Insurer:
Name of Insurer & Contact Details:
Type of cover:
Claim Number: **Policy Number:**
Amount Claimed/Claimable:
Attach a copy of the claim acceptance letter, Benefit Statement, other correspondence
Name of Superannuation Fund:
Please confirm you have checked whether you have any Income Protection Cover with your Fund:

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 or its representatives with 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 Employer, Insurer, Superannuation Fund or other organisation or body through which I am or may claim similar benefits to furnish Proclaim with all information with respect to coverage and claims for 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 Holders Name(s): _____

BSB Number: ☐☐☐ --- ☐☐☐

Account Number: _____

Swift Code (for International Account only) _____

EMPLOYER STATEMENT

Claimant Name					
When did Claimant cease work due to this Injury/Sickness?					/ /
Date claimant was employed by 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	/ /
Claimant's Job Title:					
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	ACT	Postcode	
Telephone Number					
Email:					
Signature:					
Name:					
Position:					
Date Completed:	/ /				

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:
Date of Onset of Sickness / Date of Injury: / /
When did you first examine the patient? / /
Please give full details of circumstances of injury/onset of illness:
Please detail the patient's symptoms:
What was your clinical diagnosis?
If not with you, when did the patient first receive medical attention for this condition? / /
From whom:
Has the patient ever suffered with this or any similar condition before the present episode?
If YES, please give details including dates treatment and consultation: Yes
Are you the patient's usual doctor? Yes
If NO, please give name and address of claimant's usual doctor:
DISABILITY
On what date did incapacity commence? / /
Is patient still incapacitated? Yes
If YES please estimate when you estimate the patient to be able to return to work? / /
OR Please complete:- I estimate the patient should have functional capacity to return to work in _____ days or _____ weeks or _____ months or other_____
I intend to review the patient on: / /
If the patient is no longer disabled, when did he/she return to work? / /
Please detail any investigations and provide results:-

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Any other comments/clinical findings?
Was the patient hospitalised as a result of this condition? Yes
If yes, which Hospital?
How many days was the patient hospitalised? ___ Days From: / / To: / /
Detail any Surgical Procedures performed or planned:
Procedure:
Date performed/to be performed:
Procedure:
Date performed/to be performed:
Have you referred the patient to any other Medical Practitioner? Yes
(Name & Speciality)
Detail any Treatment recommended? i.e. physiotherapy
Is there any other injury, illness or condition impacting the patient's recovery from the claimed condition?
Is the condition due to Injury or Sickness arising out of the patient's employment? Yes
If yes, have you discussed Workers' Compensation with the patient?
Do you believe the patient will recover or is any Permanent Impairment likely? Yes
Signed: Date: / /
Please use validation stamp or complete in block capitals:-
Doctor's Name:
Qualifications:
Practice/Clinic:
Address:
Telephone No:
Fax Number:
Email:
Or Validation Stamp:

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