Individual Personal Accident & Sickness Claim Form

Solution Underwriting Agency Pty Ltd

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Important information

This claim form has been issued to assist the insured to notify a claim under a **professional indemnity** policy. The issue of the claim form does not indicate acceptance of the claim.

Do not admit liability.

- Make sure you provide all the details about your claim.
- The insurer will acknowledge receipt and assign a dedicated claims specialist who will contact you or your broker within 2 business days.
- Within 10 business days you will be advised by the insurer if any further information is required to consider coverage within 10 business days following receipt of a new claim.

Definitions

In this form:

us, we means Solution Underwriting Agency Pty Ltd;
you, your means the insured making the claim
insurer means the insurer named in your insurance policy.

Privacy

We will collect your completed claim form and the accompanying Information from your broker and from yourself and forward this information to the insurer.

We are bound by the Privacy Act 1988 (Cth). Before providing us with any personal or sensitive information ('Information'), you should know that:

- We collect, use, process and store personal information and, in some cases, sensitive information about you such as health information, in order to comply with our legal obligations, to provide the claim form to the insurer to allow it to assess your claim application and manage your claim ('purposes').
- If you do not agree to provide us with the Information, the insurer may not be able to process your application or assess and / or pay your claim.
- By providing us with your Information, you consent to our use of this Information and where relevant for the purposes, you consent to our disclosure of your personal information, including your sensitive information,to us, the insurer and reinsurers, your broker, service providers, business partners, medical and health practitioners, government offices and agencies, regulators, law enforcement bodies, your employer, authorities and as required by law within Australia or overseas. The insurer may obtain Information from government offices the parties listed above and third parties to administer policies and assess a claim in the event of loss or damage.
- In most cases, on request, we will give you access to personal information held about you. In some circumstances, we may charge a fee for giving this access, which will vary but will be based on the costs to locate the information and the form of access required.
- For further information about our Privacy Policy please refer to the Privacy link on our homepage – www.solutionunderwriting.com.au contact us by telephone on 03 9654 6100 email us at solution@solutionunderwriting.com.au

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 requested information/documentation.
- You have signed this claim form.
- Your attending doctor fully completes the statement.

Important note: All medical certificates must state the reason for your disablement (e.g. "medical condition" cannot be accepted)

Part 1 – Claimant details

Policy number:

Name of insured:

Date of birth:

Occupation:

Address:

State:

Postcode:

Home telephone:

Work telephone:

Mobile:

Email:

Part 2 – Claims for injury/illness/death

What is the injury or illness?

If injured, how exactly did it occur?

Do you consider your injury to have been caused by your work? Yes ☐ No ☐

When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed?

Date: (DD/MM/YY) / /

Did the injury or illness cause you to stop work? Yes ☐ No ☐

If **YES**, please provide the date you stopped work:

Date: (DD/MM/YY) / /

Are you a fulltime, part time or casual employee?

Have you returned to work full-time, part-time or casual?

If **YES,** please provide the date you returned to work:

Date: (DD/MM/YY) / /

What hours are you working?

Days: Hours:

Details of your usual duties, before injury or sickness:

Are you currently on a claim for any injury or sickness not including this claim? Yes ☐ No ☐

If **YES**, please provide the date the claim commenced:

Date: (DD/MM/YY) / /

Who is your usual family doctor?

Doctor's name: Telephone number:

Clinic's name:

Address:

How long have you been treated by your family doctor?

When did you first get treatment from a medical practitioner for this condition?

Doctor's name: Telephone number:

Address:

Were you hospitalised for this condition? Yes ☐ No ☐

If **YES**, please provide the date you were hospitalised:

Date: (DD/MM/YY) / / to / /

At which hospital?

Details of any surgery performed:

During the 24 hours before the injury, did you drink any alcohol/take any drugs? Yes ☐ No ☐

If **YES**, please provide the following details:

Types and quantities:

Have you ever suffered this injury/illness or a similar condition before? Yes ☐ No ☐

If **YES**, please provide details:

Are you affected by any long term or chronic disability? Yes ☐ No ☐

If **YES**, please provide details:

Part 3 – Other benefits

Are you entitled to claim compensation from your Superannuation Fund or any insurance through your Superannuation Fund? Yes ☐ No ☐

Name of Superfund:

Membership number:

Are you entitled to claim insurance or compensation from any other insurance company? e.g. workers compensation, private health insurance? Yes ☐ No ☐

If **YES**, please provide details:

Name of organisation/Insurer:

Contact Details:

Type of Cover:

Amount Claimed:

Claim Number:

Attach a copy of the claim acceptance letter, Benefit Statement, other correspondence.

Declaration

I declare that, to the best of my knowledge and belief, the information in this form is true and correct and I understand the claim may be refused or reduced if information is withheld.

I understand that I may have to provide relevant documentation to enable complete consideration of my claim.

I consent to Solution, my insurance broker and the insurer and its agents using the personal information I have provided on this form for the purposes of processing my claim. I consent to the disclosure of sensitive information to third parties in order to process this claim. I consent to the disclosure of any personal information (including sensitive information) overseas where it is reasonably necessary for the processing of the insurance claim.
I understand that if this consent is not given the insurer and its agents will not be able to process this insurance claim.

Signature of insured or person with authority to sign for and on behalf of a company or partnership.

Signature

Applicant's Signature:

Applicant's Name:

Date: / /

Please indicate the number of additional pages attached to this claim form:

Solution Underwriting Agency Pty Ltd is forwarding this claim form on behalf of the Insurer named in your policy of insurance.

BANK ACCOUNT DETAILS

Bank:

BSB number:

Account name(s):

Account number:

Employer or principal contractor statement

Claimant name:

When did the claimant cease working for this Injury/Sickness? Date: (DD/MM/YY) / /

Is the claimant currently off work on an unrelated claim? Yes ☐ No ☐

Date of employment with the company:
Date: (DD/MM/YY) / /

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? Yes ☐ No ☐

If **YES** when will/was the workers' compensation claim lodged?

Date: (DD/MM/YY) / /

If **YES**, what is the weekly compensation?
(Please attach all workers' compensation correspondence) $

What payments have been made to date during the period of disablement?

Details	Dates	Amount
Workers' compensation		A$
Normal pay		A$
Sick pay		A$

What is the usual occupation of the claimant?

What are his/her usual duties?

Has the claimant returned to work? Yes ☐ No ☐

If **YES**, please provide date claimant returned to work:

Date: (DD/MM/YY) / /

Name of company:

Address:

Suburb:

State:

Postcode:

Home telephone:

Email:

Name:

Position:

Signature:

Doctor's statement

Patient's name:

Date of birth: (DD/MM/YY)

Height:

Weight:

Please give full details of circumstances of injury/onset of illness:

Final diagnosis:

Date of onset of sickness/date of Injury:

Date: (DD/MM/YY) / /

When did the patient first receive medical attention for this condition?

Date: (DD/MM/YY) / /

Was the disability sports related? Yes ☐ No ☐

If **YES**, please provide details:

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

If **YES**, please provide details:

Has the patient ever suffered with this or any similar condition before the present episode? Yes ☐ No ☐

If **YES**, please give details including dates of treatment and consultation:

Are you the patient's usual doctor? Yes ☐ No ☐

If **NO**, please give name and address of patient's usual doctor:

Name of doctor:

Address:

When did the patient first consult you for this condition?

Date: (DD/MM/YY) / /

On which date did incapacity commence?

Date: (DD/MM/YY) / /

How long have you been treating the patient?

Is patient still incapacitated? Yes ☐ No ☐

If **YES**, please estimate when you expect the patient to be able to return to full time work or part time work?

Date: (DD/MM/YY) / /

Working hours:

Capacity:

Restrictions:

If **NO**, when did incapacity cease?

Date: (DD/MM/YY) / /

Was the patient hospitalised as a result of this condition? Yes ☐ No ☐

How many days was the patient hospitalised?

Days:

Date: (DD/MM/YY) / / 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 ☐

Signature of doctor:

Qualifications:

Please use validation stamp or complete in block capitals:

Name:

Address:

Telephone:

Fax:

Email:

Validation Stamp:

SEND CLAIM FORM TO:

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Any queries, please contact us

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Solution Underwriting Agency Pty Ltd is forwarding this claim form on behalf of the Insurer named in your policy of insurance.