Injury or Sickness Benefit Claim Form

The supply or acceptance of this form is not an admission of liability on the part of Allianz.

Claim Number _____

General information

Name of insured _____

Contact person _____

Telephone no. Home ( ) _____ Work ( ) _____ Mobile no. _____

Email _____

Postal address _____

_____ State _____ Postcode _____

Broker/Agent name _____

Telephone no. ( ) _____

Policy no. _____

Excess $ _____

Inception Date ___/___/___ Expiry date ___/___/___

GST

Are you registered for GST purposes? ☐ Yes ☐ No

ABN _____

To what extent are you entitled to claim an Input Tax Credit for this policy? _____ %

Claimant

Claimant's name _____

Date of birth ___/___/___

Relationship to insured _____

Postal address _____

_____ State _____ Postcode _____

Residential address _____

_____ State _____ Postcode _____

Telephone no. Home ( ) _____ Work ( ) _____ Mobile no. _____

Occupation _____

Average gross weekly earnings (over last 12 months) $ _____

Employment

Are you employed by someone else? ☐ Yes ☐ No

If Yes, name of employer _____

Telephone no. ( ) _____

Nature of employment ☐ Full Time ☐ Part Time ☐ Temporary

Are you self-employed? ☐ Yes ☐ No

If Yes, trading/business name _____

Was your business fully operational and were you fully employed at the time of injury/sickness? ☐ Yes ☐ No

Please give details _____

Give the extent and duration of your usual working hours?

Extent Days _____ Duration Hours _____

Employment history

Have you engaged in employment other than your normal occupation since this Policy was issued? ☐ Yes ☐ No

If Yes, please give details _____

Have you been able, since the injury/sickness occurred, to attend to your usual occupation, profession or business (or any portion of it)? ☐ Yes ☐ No

Please give details _____

Medical history

Have you in the past received medical advice or treatment in respect of the injury or illness now being claimed? ☐ Yes ☐ No

Please give details _____

Definitions

Temporary Total Disablement means disablement which entirely prevents you from engaging in your usual occupation, profession or business.

Temporary Partial Disablement means disablement which entirely prevents you from carrying out a substantial part of the duties normally undertaken by you in connection with your usual occupation, profession or business.

Disablement

The Date disablement commenced (date) ____/____/____

I have been totally disabled for _____ days From _____ to _____

I have been partially disabled for _____ days From _____ to _____

I am now ☐ Not disabled ☐ Totally disabled ☐ Partially disabled

How much longer is the disability likely to continue? _____

Other insurance

Are you Insured elsewhere for injury or sickness? ☐ Yes ☐ No

If Yes, name of each Insurer _____

Are you eligible for Workers' Compensation? ☐ Yes ☐ No

Have you claimed or are you claiming for Workers' Compensation benefits? ☐ Yes ☐ No

If Yes, who is your Insurer? _____

Date claim lodged ____/____/____

Claim no. _____

Injury

Location where injury occurred _____

Particulars of incident _____

Date of injury ____/____/____ Time _____AM / PM

What were you doing at the time of the injury? _____

How did the injury occur? _____

Name and extent of injuries _____

Have you suffered from this type of injury before? ☐ Yes ☐ No

Please give details _____

Sickness

Date the sickness was first contracted ____/____/____

Nature of sickness _____

How and where contracted? _____

Have you suffered from this sickness before? ☐ Yes ☐ No

Please give details _____

Treatment

Name of medical attendant who attended this condition _____

Address _____

_____ State _____ Postcode _____

Name of your regular medical attendant _____

Address _____

_____ State _____ Postcode _____

Please attach any medical certificate(s) or report(s) that are in your possession for this Injury/Illness

Medical authority

I authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the underwriter any information it requires of any sickness or injury to me or my physical or mental condition or prognosis, or my employment to assist in the proof and settlement of my claim. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

Signature _____ Date ___/___/___

Business expenses

Are you claiming for business expenses? ☐ Yes ☐ No

Please give details _____

Nominated Expense	Date Incurred	Amount
	/ /	$
		$
		$
		$
		$
		$

Please attach documentation to support Business Expenses.

Please arrange for the Medical Certificate section of this form to be completed by the doctor who you consulted for this injury or sickness.

Privacy Notice

The personal and sensitive information collected in this form and other information you or third parties provide in connection with this claim will be used to process this claim, compile and analyse data, and resolve claim disputes. If you do not provide this information to us we may not be able to process this claim.

We may have to disclose your personal and other information to third parties who assist us in assessing and processing this claim, including other insurers, health service providers, investigators, our specialist advisors, our service providers or as required by law.

You have the right to seek access to your personal information and to correct it at any time. For information about how you may access and request correction of personal information we hold about you, or complain about a breach of the Australian Privacy Principles, please see our privacy policy available at www.allianz.com.au or contact us on 1300 360 529 EST 9am-5pm, Monday to Friday.

IDR Statement

Disputes are not an everyday occurrence at Allianz. However we do provide an internal dispute resolution process should any dispute arise. Please feel free to ask for details.

If you are not satisfied with the outcome of this process, we will advise you how to contact the insurance industry's external independent complaints scheme (subject to eligibility).

Declaration

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld.

I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We acknowledge that I/we have read and understood the Privacy Act 1988 information referred to above and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons affected by this claim, with their approval.

I/We acknowledge that if I/we do not agree to the collection of this personal and sensitive information then Allianz will be unable to process my/our claim.

Signature of Insured _____ Date ___/___/___

Medical Certificate

At your own expense, you must have this certificate completed by a duly qualified Medical Practitioner, who is requested to return this Claim Form directly to us within 7 days.

Name of Attending Physician (please print) _____

Qualifications _____

Address

_____ State _____ Postcode _____

Name of Patient (please print) _____

If you are unable to answer any of the questions below, please indicate.

Describe injury/sickness _____

_____

_____

When did you first treat the Patient for this condition? Date ____/____/____

Has this patient been referred to you? If so, please provide name and contact details of the referring doctor _____

_____

_____

How long has this condition (in your opinion) been in existence? _____

Please provide all treatment dates for this condition _____

_____

Present condition

Prognosis _____

If hospitalised, give dates From ____/____/____ to ____/____/____

Name of Hospital _____

Describe any surgery _____

Have you any reason to suppose that the patient was under the influence of intoxicants at the time of the accident? ☐ Yes ☐ No

Date patient was Totally Disabled ____/____/____

When did you release the patient to perform regular duties? Date ____/____/____

When did you release the patient to perform light duties? Date ____/____/____

In your opinion, probable further disability should not exceed Weeks _____ Months _____

Medical History

Has the patient previously suffered from the same or a similar injury or sickness? ☐ Yes ☐ No

If Yes, date diagnosis ____/____/____

Name of Physician who previously treated patient _____

Were there any complications? ☐ Yes ☐ No

If Yes, please give details _____

Are the patient's symptoms due or traceable exclusively to this previous Injury/Sickness? ☐ Yes ☐ No o

Is there anything in the patient's medical history which may have contributed, directly or indirectly, to the Injury/Sickness or which may be likely to retard the patient's recovery? ☐ Yes ☐ No

Please give details _____

_____

_____

Signature of Attending Physician _____ Date ____/____/____