Claim Form

CORPORATE
SERVICES
NETWORK

Liberty
Specialty Markets

JOURNEY

Important Notice

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. 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 Corporate Services Network.

Instructions

1. Please **fully** complete Sections 1 - 5 of the claim form.
2. Ensure you sign the Medical Authority and Declaration (Section 5).
3. For the Self Employed, please provide your tax assessment advice from the ATO for the previous financial year as proof of your income.
4. For Employees, please have your Employer fully complete Section 6 of the claim form and include 12 months payroll history prior to the date of disablement.
5. Your Doctor completes the Medical Practitioner's Statement (Section 6).
6. Scan and email the claim form through to **liberty@csnet.com.au**

We cannot proceed with the claim without this information

Liberty Specialty Markets
c/- Corporate Services Network
GPO Box 4276, Sydney NSW 2001

T: +61 2 8256 1770
F: +61 2 8256 1775
E: liberty@csnet.com.au

1. POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

Employer's name		Policy no	
Title	Given name(s)		Male ☐ Female ☐
Family name		Date of birth	
Residential address			
Suburb	State	Postcode	
Postal address			
Do you consent to us communicating with you by email?	Yes ☐ No ☐ Email		
Daytime contact number	Alternative number		
Occupation, trade or profession			
Work site/location			
For what are you claiming?	Weekly benefit ☐ Capital benefit ☐		

2. EFT AUTHORISATION

I hereby authorise and request that Corporate Services Network credit my bank account as indicated below

Account holder's name		
BSB no	Account no	Bank

3. DETAILS OF ACCIDENT & INJURY

Date of event	Time	AM ☐	PM ☐

Were you the driver, rider OR a passenger? Driver ☐ Rider ☐ Passenger ☐ Other ☐

If "Other", please provide specific details

PLEASE PROVIDE US WITH A COPY OF YOUR MOTOR VEHICLE LICENCE (FRONT AND BACK)

Is your licence currently valid? Yes ☐ No ☐

If "No", please explain why? (i.e suspended, cancelled etc.)

What type of vehicle were you in at the time of injury? Motorbike ☐ Car ☐ Truck ☐ Bus ☐ Van ☐ Other ☐

If "Other", please provide specific details

Address where accident occurred

Type of road condition where incident occurred? Dirt ☐ Bitumen ☐ Concrete ☐ Sealed surface ☐ Other ☐

If "Other", please provide specific details

Please describe how the accident occurred

Where were you travelling to at the time of the event?

Where were you travelling from at the time of the event?

Were you working at the time of the event? Yes ☐ No ☐

When did the event occur? During business hours ☐ After business hours ☐

Did the Police attend the scene? Yes ☐ No ☐

If "Yes", please name the police officer, station and Event Number

If Police did not attend the scene, was the event still reported to the police? Yes ☐ No ☐

If "Yes", please name the police officer, station and Event Number

IF YOU HAVE A COPY OF THE POLICE REPORT, PLEASE PROVIDE US WITH A COPY.

If the event was not reported to the police, why?

Who did the police find at fault for the Incident?

N/A ☐ Myself ☐ Other driver ☐ No one ☐ Under investigation ☐

What action was taken by the Police against the person who was at fault for the incident?

N/A ☐ Traffic fine ☐ Court summons ☐ Arrest ☐ TBA ☐

Did the police subject you to any of the following RBT ☐ RDT ☐ Blood test ☐

Were you on any medication at the time of the event? Yes ☐ No ☐

If "Yes", please provide medication details, the reason for use, and the time it was consumed prior to Event

Were you suffering any illnesses at the time of the event? Yes ☐ No ☐

If "Yes", please provide details of Illness

Did you consume any alcohol in the 6 hours prior to the event? Yes ☐ No ☐

If "Yes", please advise

Time commenced drinking alcohol Time AM ☐ PM ☐

Time before the incident you ceased drinking alcohol Time AM ☐ PM ☐

Type of alcohol: Beer ☐ Wine ☐ Spirits ☐ Mixed drinks ☐ Other ☐

If other, please provide details

Approx. how many beverages did you consume?

Where were you drinking? (i.e. Home, Bar, etc.)

Did you take/consume any drugs and/or prescribed medication of any kind in the 6 hours prior to the event? Yes ☐ No ☐

If "Yes", please advise

Time commenced consuming/taking the drug(s) and/or prescribed medication before event AM ☐ PM ☐

Type of drug(s) and/or prescribed medication consumed/taken

Approx. how much of the drug(s) and/or prescribed medication consumed/taken?

What were the injuries?

Have you previously been treated for a similar or same injury? Yes ☐ No ☐

If Yes, please give details

4. TREATMENT RECEIVED

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

When did you stop work? Time AM ☐ PM ☐

When did you first obtain treatment from doctor? Time AM ☐ PM ☐

Name of current treating doctor

Clinic name/address

Name of regular doctor

Clinic name/address

Date first consulted doctor Date last consulted doctor

How long have they been your regular doctor? Years Months

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

Is there any condition (past or present) affecting your current disability? Yes ☐ No ☐

If Yes, please give details

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, or are you entitled to 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 no (if known)	Name	Address
Employer			
Workers' Comp/ Transport Insurer			

Name of your Superfund

Superfund Membership No

Are you entitled to Income Protection Benefits through your Superfund? Yes ☐ No ☐

If yes, have you made a claim? Yes ☐ No ☐

Claim Reference Number

5. MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither Corporate Services Network (CSN) or Liberty Specialty Markets (Liberty) have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN or Liberty 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 CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN or Liberty such personal information (including health information) as CSN or Liberty in their 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 CSN or Liberty 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, CSN or Liberty may not be able to process or assess my claim.

I appoint CSN or Liberty 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

Privacy Notice

Liberty Specialty Markets (Liberty) and Corporate Services Network (CSN) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information. For the purposes of this Privacy Notice, 'we', 'us' or 'our' refers to, if the context permits, both Liberty and CSN.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and CSN collects personal information in order to provide claim assessments and insurance related services. Liberty and CSN 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 Liberty and CSN. If you do not provide the personal information Liberty, CSN or other relevant third parties require to offer you specific products or services, Liberty or CSN 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 Liberty or CSN collects or handles your personal information please write to Liberty's Privacy Officer at **privacy.officer.ap@libertyglobalgroup.com** or call +61 2 8298 5800 and/or CSN's Privacy Officer at **privacy@csnet.com.au** or call +612 8256 1770.

To obtain a copy of Liberty's Privacy Policy go to Liberty's website (libertyspecialtymarkets.com.au) or request a copy from Liberty's Privacy Officer. To obtain a copy of CSN's Privacy Policy go to CSN's website (csnet.com.au) or request a copy from CSN's Privacy Officer.

When you give Liberty or CSN personal or sensitive information about other individuals, Liberty and CSN 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.

6. TO BE COMPLETED BY YOUR EMPLOYER

Employers name

This is to certify that _____

has been unable to attend their occupation as a result of Injury

From Until

Were they scheduled to attend OR attended work on the day of accident/injury? Yes ☐ No ☐

Their average Gross Weekly Salary (as defined by the policy wording)
averaged over the previous 12 months at the time of this accident/injury was AUD$

PLEASE ATTACH THE EMPLOYEE'S PAY HISTORY FOR THE 12 MONTHS PRIOR TO THEIR LAST DAY AT WORK

Employee's Occupation

Type of Employment Permanent full time ☐ Permanent part time ☐ Casual ☐ Fixed term/Contract ☐

Are they still employed? Yes ☐ No ☐ If no, please provide the last date they were employed

Their sick leave entitlement as at the date of injury or illness Days

They have been employed since

Has a claim for Workers' 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 Date

6. MEDICAL PRACTITIONER'S STATEMENT TO COMPANY

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

Patient's name	Date of birth
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

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 was hospitalised please provide	Admission date	Discharge date

Name of hospital

Has the patient had surgery or is it anticipated?	Yes ☐	No ☐

Provide details

Date performed or anticipated

Give name of hospital

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

Was the patient referred by you or to you? Referred ☐ Referring ☐

Provide details

Doctor's details

Date of referral

Is the patient still disabled?

No ☐ when did the patient return to work?

Yes ☐ how long will the patient be

– totally disabled (unable to perform any part of their occupation) from to

– partially disabled (able to perform part of their occupation) from to

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers' Compensation insurer, Social Security, sports body or any other insurance body? Yes ☐ No ☐

Name of Company/Contact/Claim Number

Signature of medical practitioner

Name and qualifications (print)

Address

Telephone Date

WHAT TO DO WHEN FORM IS COMPLETE

1. Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employer and Medical Practitioner have signed this form.
2. Send this form to:
   Liberty Specialty Markets
   c/- Corporate Services Network
   GPO Box 4276
   Sydney NSW 2001
   liberty@csnet.com.au