Claim Form

FULLERTON HEALTH | CORPORATE SERVICES

Liberty Specialty Markets

PERSONAL ACCIDENT & SICKNESS

Important Notice

This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.

This form can be completed electronically. If completing this form by hand: Please print.

The issue of this form is not an admission of liability.

Once completed please either email or mail the claim form to Fullerton Health Corporate Services.

Instructions

1. You **fully** complete Sections 1 - 5 of the claim form including either the illness or injury statement. We cannot proceed with the claim without this information
2. Ensure you sign the Privacy Declaration (Section 7)
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 8 of the claim form and include 12 months payroll history prior to the date of Disablement
5. Your Doctor completes the “Medical Practitioners Statement”
6. Scan and email the claim form through to **liberty@fullertonhealthcs.com.au**

GPO Box 4276
Sydney NSW 2001

T: +61 2 8256 1770
F: +61 2 8256 1775
E: liberty@fullertonhealthcs.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 ☐ Death benefit ☐

2. EFT AUTHORISATION

Please tick preferred method of Payment for refund. Direct/EFT payment ☐ or Cheque ☐

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

For Direct/EFT payment

Account holder's name

BSB no | Account no | Bank

For Cheque payment

Payee

3. DETAILS OF INJURY – COMPLETE IF AS A RESULT OF ACCIDENT

Date of accident | Time | AM ☐ PM ☐

Address where accident occurred

Were there any witnesses to the accident? Yes ☐ No ☐

Witness name

Witness address

Please describe how the accident/injury occurred

What were the injuries?

Have you previously been treated for any serious injury? Yes ☐ No ☐

If Yes, please give details

Give details of any previous claim made for any previous injury against any insurance company (please attach separate sheet if insufficient)

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

If Yes, please state types & quantities

4. TO BE COMPLETED IF DISABILITY IS AS A RESULT OF AN ILLNESS/SICKNESS

The nature of illness

When did the illness begin?

Have you had this complaint before? Yes ☐ No ☐

If Yes, when and how long were you disabled?

5. TREATMENT RECEIVED FOR INJURY/ILLNESS

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

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

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctor's name Address Telephone number

When did you stop work? Time AM ☐ PM ☐

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

Name of doctor

Address

Is this doctor still treating you for the injury/illness? Yes ☐ No ☐

Is this doctor your regular doctor? Yes ☐ No ☐

If No, please give details

Name of regular doctor

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, a claim for benefits under any Worker's Compensation Act or Transportation Act because of this injury? Yes ☐ No ☐

If Yes, please give details

	Claim no (if known)	Name	Address
Employer			
Worker's Comp/ Transport Insurer			

Are you entitled to claim benefits for this Injury/Illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? Yes ☐ No ☐

If Yes, please give details

Name	Address

6. TO BE COMPLETED BY PERSON MAKING A CLAIM FOR DEATH BENEFIT

Name of person completing the form

Telephone Email

Company name (if applicable)

Address

Relationship with deceased Employer ☐ Next of kin ☐ Executor ☐ Family doctor ☐ Lawyer ☐ Other ☐

If next of kin, state relationship

The following items must be included with this claim.
– Certified copy of Death Certificate
– Certified copy of Original Birth Certificate
– Copy of the Coroner's Depositions & Findings (if applicable)

Was a coronial inquest held or is one being held? Yes ☐ No ☐

If so, give details below

7. MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither FHCS 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 FHCS 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 FHCS's Privacy Officer.

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

I appoint FHCS 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 Fullerton Health Corporate Services (FHCS) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and FHCS collects personal information in order to provide claim assessments and insurance related services. Liberty and FHCS 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 FHCS. If you do not provide the personal information Liberty, FHCS or other relevant third parties require to offer you specific products or services, Liberty or FHCS 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 FHCS 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 FHCS'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 FHCS's Privacy Policy go to FHCS's website (fullertonhealthcs.com.au) or request a copy from FHCS's Privacy Officer.

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

8. TO BE COMPLETED BY YOUR EMPLOYER

Employer's name

This is to Certify that _____

has been unable to attend his/her occupation as a result of injury or illness

From Until

His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this injury/illness was

Has your employees last 12 months payroll history been attached with this report, and if not please provide Yes ☐ No ☐

His/Her sick leave entitlement as at the date of injury or illness Days

He/She has been employed since

Please confirm if he/she are still an employee Yes ☐ No ☐

Please confirm date they were no longer employed

Has a claim for Worker's 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

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 illness arising out of the patient's employment?	Yes ☐	No ☐

Provide details

Was the disability sports related?	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, Worker's 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