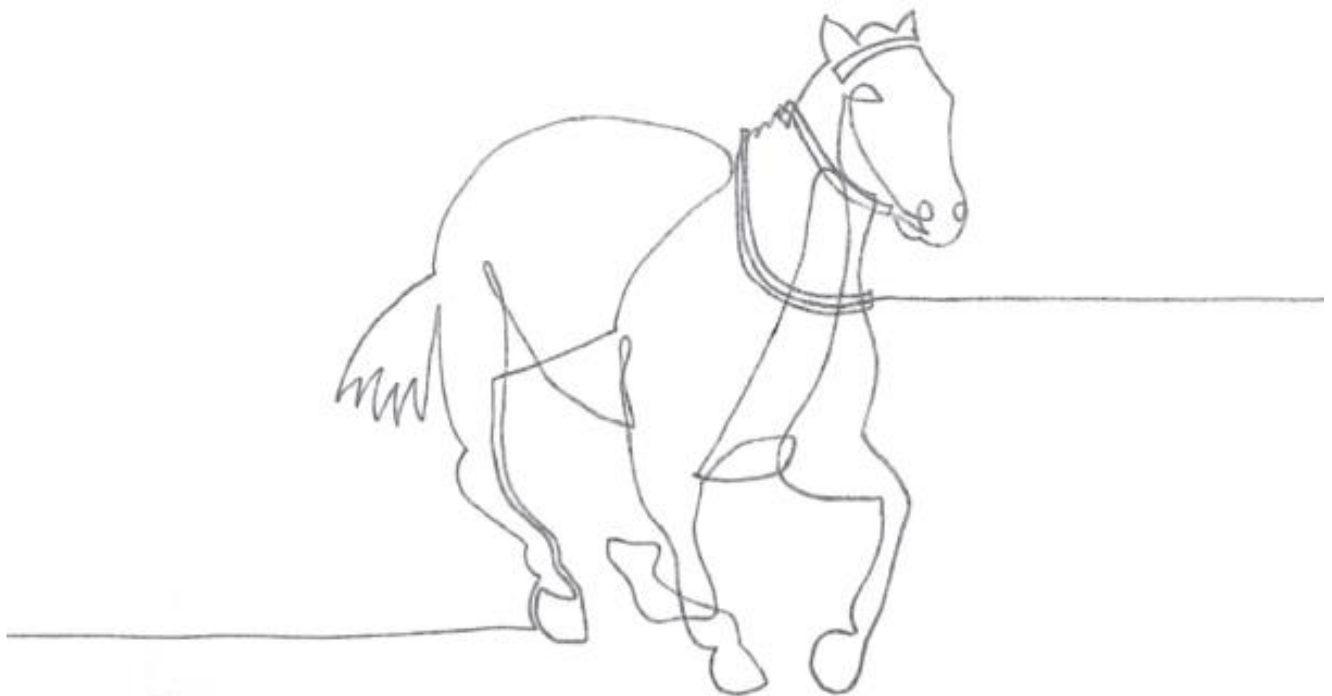
Beazley | Group Personal Accident Insurance

claim form



Personal Accident Insurance Claim Form

IMPORTANT INFORMATION

We act upon your claim as soon as we receive this form. You can help us in the assessment of your claim, if you:

1. Complete this form in full. Supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents as indicated may result in a delay in processing your claim.
2. Provide a comprehensive description of the circumstances of the accident and your injury.
3. If this claim form does not provide enough space, please use a separate piece of paper and attach as supplementary information.
4. When all information has been completed, please forward the claim form to **Equestrian Sports Insurance (ESI).**

CLAIMANT DETAILS

Surname	Given Name(s)	

Residential Street Address

Suburb	State	Postcode

Postal Address (if different from above)

Suburb	State	Postcode

Home Phone Number	Mobile Phone Number

Email Address

Date of Birth	Sex	Height	Weight
	☐ Male ☐ Female	cm	kg

Employer's Name

Usual Occupation

POLICY DETAILS

Please tick which Part of the policy you are claiming:

☐ **Part A** – Lump Sum Benefits

☐ **Part B** – Weekly Benefits – Injury

☐ **Part C** – Injury Resulting in Fractured Bones

☐ **Part D** – Additional Benefits under the Policy

If you are claiming under **Part D**, please tick which Benefit you are claiming:

☐ Bed Care Benefit	☐ Non-Medicare Medical Benefit
☐ Domestic Home Help Benefit	☐ Out of Pocket Expense
☐ Education Fund Benefit	☐ Parents Inconvenience Allowance
☐ Funeral Benefit	☐ Vocational Assistance Benefit
☐ Injury Assistance Benefit	☐ Student Tutorial Benefit

CLAIM DETAILS – To be completed by the Claimant

What is the nature of your injury?

When did your injury occur? (please provide date and time)

Date: | Time: am / pm

How did your injury occur?

Where were you when you sustained your injury? (please provide street address, suburb and state)

On what date did you first receive attention/treatment from a medical practitioner for your injury?

Date:

Doctor's Name

Address

Contact Telephone Number

Did anyone witness you sustaining your injury? ☐ No ☐ Yes – provide details

Witness name(s), address and contact telephone numbers:

Did the injury cause you to stop working? ☐ No ☐ Yes – provide details

If yes, as of what date?

Date:

Have you returned to work full-time? ☐ No ☐ Yes – provide details

If yes, as of what date?

Date:

OR

Have you returned to work part-time? ☐ No ☐ Yes – provide details

If yes, as of what date?

Date:

What hours and duties are you working?

Was your injury caused by your employment? ☐ No ☐ Yes

Name of your usual family Doctor

Name of Surgery or Practice

Address

Contact Telephone Number

How long have you been a patient of this Doctor/surgery?

months	years

Please provide a list of all Doctors and Medical Practitioners whom you have consulted in the last 5 years:

Did you go to hospital for your injury? ☐ No ☐ Yes – provide details

Hospital Name and Address:

Dates of Admission and Discharge:

Admission:	Discharge:

Please also obtain and provide a copy of the Discharge Summary from the Hospital.

Have you ever had this or similar condition in the past? ☐ No ☐ Yes – provide details

Treatment dates and treatment received:

Names of all treating doctors/Specialists and their addresses:

Have you consulted any other Doctor for your injury? ☐ No ☐ Yes – provide details

Doctor's Name

Address:

Contact Telephone Number:

Period over which consultations took place:

OTHER INSURANCES / BENEFITS

Are you entitled to make a claim, or have you ever made a claim previously for your injury / sickness against any of the following sources:

Workers Compensation	☐ No	☐ Yes
Motor Accident Compensation	☐ No	☐ Yes
Other Salary Continuance Insurance	☐ No	☐ Yes
Centrelink	☐ No	☐ Yes
Other	☐ No	☐ Yes

If yes to any of the above, please provide details in the below table:

Amount	Date from (dd/mm/yyyy)	Date to (dd/mm/yyyy)	Ref No.	Name and contact details of benefit provider

Have you ever made a previous claim in respect to Accident and Sickness Insurance? ☐ No ☐ Yes – provide details

Please provide details of Insurer and claim number:

Please provide the name of your Superannuation Fund and Member Number:

Do you have Income Protection cover under your Superannuation policy? ☐ No ☐ Yes – provide details

Please provide details:

SALARY DETAILS – complete whichever section is applicable

1. If Self-Employed:

If you are not an employee, your weekly pre-tax income derived from personal exertion during the period of twelve (12) months immediately preceding the date of Temporary Total Disablement or Temporary Partial Disablement, or during such shorter period as you have been self-employed in your usual occupation at the time the disability occurred, <u>must be supplied</u>. Income is net of business costs and expenses incurred in deriving that income.

Your Accountant's Name:

Address:

Telephone Number:

What is your employment / position status? (i.e. Director, Partner, Sole-Trader etc.)

2. If you are Employed as a wage earner (this section is to be completed by your Employer):

I hereby certify that

has been unable to attend their usual occupation as a result of their injury which was sustained on

What was the Employee's last day at work?

When is the Employee expected to / did resume usual duties?

When did the Employee commence employment with the company?

What is the Employee's usual occupation?

Has the Employee lodged or is intending to lodge a Workers' Compensation claim? ☐ No ☐ Yes – provide details

Employee's gross salary, averaged over the 12 months immediately preceding disablement (or over the period between first date of employment and disablement if employed less than 12 months):

Is there any other additional information that you would like to provide in relation to the submission of this claim?

Signature of Supervisor or Paymaster:	
Name of Supervisor or Paymaster:	
Name of Company:	

REQUEST FOR BENEFIT PAYMENT BY ELECTRONIC FUNDS TRANSFER – please complete the following

Name of Bank:

BSB Number: Account Number:

Name of Account (in full):

Signature:

Name (please print): Date:

CLAIMANT AUTHORITY AND DECLARATION

I hereby authorise any hospital, physician, insurer, health insurance commission, employer or other person who has attended me to supply Gallagher Bassett with any and all information with respect to any injury or sickness, medical history, consultation, prescriptions or treatment, including copies of all my hospital and/or medical records, including any and all financial information and details of any paid entitlements with respect to the claimed injury or sickness.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said claim, make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the Policy shall be void and all rights to recover thereunder in respect of past, present or future claims will be forfeited.

I agree that a scanned, photocopied or faxed copy of this authority shall be considered as effective and valid as the original.

Signature of Claimant:	
Name of Claimant (Please Print):	
Date:	

Privacy

The Privacy Act 1988 (as amended) seeks to ensure the confidentiality and security of any personal information. We are committed to ensuring that confidentiality and security.

The Gallagher Bassett Privacy Policy detailing our handling of personal information is available on request. You may request access to information held by us about you, by contacting us. You may also access our Privacy Statement on our website at https://www.gallagherbassett.com.au/privacy/

TREATING DOCTOR'S STATEMENT

PLEASE NOTE:

1. Print in black or blue ink
2. Please attach a separate page if you require more space for an answer
3. All questions must be completed by a duly qualified medical practitioner
4. **Any costs associated with the completion of this form are to be met by the patient**
5. Please complete and return to the patient

Patient's Name:

Patient's Date of Birth:

Height

Weight

Residential Street Address:

Suburb:

Postcode:

Please confirm your diagnosis.

Please state the objective findings which support the above, and attach copies of investigation reports and treating Specialist reports if available.

Is the condition an: Injury ☐ Sickness ☐

Date of first onset of symptoms:

Date the patient first consulted you for the condition:

How long has the patient attended your practice?

months

years

Please list and describe the current symptoms and the relative severity of each symptom.

What do you think caused the patient's condition?

Is the current condition in any way related to the patient's employment? ☐ No ☐ Yes

If yes, would you support a Workers' Compensation claim? ☐ No ☐ Yes

Please explain why or why not:

Has the patient ever had the same or similar condition in the past and if so, does it relate to his/her present condition? ☐ No ☐ Yes – provide details

What was the diagnosis of the previous condition?

Was this occurrence / recurrence expected? ☐ No ☐ Yes – provide details

If yes, please explain why:

Does the patient have any other condition that is contributing to overall disablement? If yes, please complete box below:

Condition	% Contribution

What treatment is the patient receiving for this condition?

Was or will the patient be hospitalised for the condition? ☐ No ☐ Yes – provide details

Details including name of hospital and dates of confinement:

Was the patient referred by or to you? ☐ No ☐ Yes – provide details

Please provide details of whom you have referred the patient to or the referring doctor.

Doctor's Name and Address:

Is the patient still disabled to work?

☐ No – when did the patient return to work?

☐ Yes – how long will the patient be:

- Temporarily totally disabled (unable to perform any part of their usual occupation)
  from: to:
- Temporarily partially disabled (able to perform part of their usual occupation)
  from: to:

If partially disabled, what duties could the patient perform and for how many hours per week?

On what date do you consider the patient will be able to return to work?

Has the patient continued to follow medical advice? ☐ No ☐ Yes

If no, please advise why:

Signature of Medical Practitioner:	
Name – please print:	Qualifications:
Name of Practice:	
Postal Address:	
Email Address:	
Telephone Number:	Fax Number: