

B.

CLAIMS FOR INJURY / ILLNESS / DEATH

What is the injury or illness?

If injury, how exactly did it occur?

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

Did the injury or illness cause you to stop work?

No Yes - When?

Have you returned to work full-time?

No Yes - When?

OR

Have you returned to work part-time?

No Yes - When?

- if Yes, what hours and duties are you working?

Days

Hours

Duties

Is this condition due to injury or sickness arising out of your employment?

No Yes - give details

If injury, how exactly did it occur?

Who is your usual family doctor?

Name

Address

Telephone Number

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

Doctor's Name

Address

Telephone Number

When did you first see the medical practitioner?

Have you consulted any other medical practitioner for this condition?

No Yes - give details

Doctor's Name

Address

Telephone Number

Period

Did you go to hospital?

No Yes - give details

Hospital Name

Address

Date of Admission & Discharge

Number of Days in Hospital

During the 24 hours before the injury, did you drink any alcohol or take any drugs??

No Yes - give details

State types & quantities

Have you ever had this or a similar condition in the past?

No Yes - give details

Date (s)

Treatment received

Name of treating Doctors/Specialists

Addresses of Doctors/Specialist who treated you

What other significant medical or surgical treatment have you received in the past 5 years? - give details

Date (s)

Nature of the condition(s) treated

Name of treating Doctors/Specialists

Addresses of Doctors/Specialist who treated you

Are you affected by any other long term or chronic disability?

No Yes - give details

C. CLAIMS FOR ADDITIONAL BENEFITS OR INJURY OR ILLNESS

NOT ALL POLICIES PROVIDE THESE BENEFITS. PLEASE ONLY COMPLETE IF APPLICABLE

Are you claiming for:-

- **homecare or income replacement after major surgery for cancer**
- **child minding or income replacement after a child's accident**
- **home tuition fees after a child's accident**
- **medical expenses not covered by Medicare**
- **damage to personal property**

Give details, specifying each item

ITEM	AMOUNT

PLEASE ATTACH INVOICES OR OTHER EVIDENCE OF THE EXPENSES YOU HAVE INCURRED OR RECEIPTS FOR DAMAGED PROPERTY.

D. OTHER INSURANCE / BENEFITS

Are you claiming insurance or compensation from any other insurance company? eg. Workers Compensation, Traffic Accident Commission, sports body or any income replacement

No Yes - give details below

Name of insured organisation / employer & telephone number

Name of Insurer & Telephone No.

Type of cover

Amount claimed per week

\$ per week

Do you have private health insurance?

No Yes - give details

Do you have ambulance cover?

No Yes - give details

E.

TO BE COMPLETED BY YOUR EMPLOYER

If Self Employed please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earnings.

Name of Employer

This is certify that of

has been unable to attend his / her occupation as a result of Injury or Sickness from / / to / /

His / Her average Gross Weekly Salary at the time of this accident / sickness was A\$

He / She has been employed since / /

His / Her Sick Leave Entitlement at the time of the accident / sickness was days

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? Yes No

Signature of Employer or Supervisor

Name of Employer or Supervisor (please print)

Telephone Number Date / /

Privacy Consent – Claim Assessment

Protection of My Privacy Acknowledgement and Consents

By signing this form I agree that ACE Insurance Limited ABN 23 001 642 020 ('ACE') and third parties such as my insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by ACE, my employers (past and present), my accountant, any business which provides information about the commercial activities of persons and if I am or have been bankrupt, the trustee of my estate (the Parties) may exchange with each other any information about me, excluding health or other sensitive information, including

- Any information provided by me in relation to my claim;
- Any other personal information I provide to any of them or which they otherwise lawfully obtain about me;
- Any information relating to this insurance or any other insurance held by me or on my life, including terms and conditions and claims history;
- Details of my employment; including position, period of employment, remuneration, hours worked and duties performed; and
- Any information relating to my income and solvency.

I agree that any information referred to above can be used by the Parties and any Service Provider (as identified below) for assessing the claim or my entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning; product development and research purposes.

I agree that ACE may exchange my personal and/or sensitive information, for the purposes of assessing the claim or my entitlement to benefits with:

- Any investigator appointed by ACE to investigate the claim;
- The Health Record Holders;
- The Health Insurance Commission;
- Other insurers;
- Reinsurers;
- Any private or government organisation which investigates fraud including the police; and
- Any witness identified by me

If I have identified any person as a witness, I agree to ensure that each person is made aware that:

- I have identified him/her as a witness in relation to the claim;
- ACE holds a record of their personal information for this purpose; and
- He/she may contact ACE or request access to his/her information, by calling 1800 815 675.

If ACE engage anyone (a 'Service Provider') to do something on its behalf (for example technology providers) then I agree to them exchanging any information referred to above, with each other:

I understand ACE might give any information referred to above to entities other than the Parties, the Service Providers, the Health Record Holders and the other persons/organisations referred to above where it is required or allowed by law or where I have otherwise consented.

I understand that I can access** most personal information that members of ACE Insurance Limited hold about me (sometimes there will be a reason why that is not possible, in which case I will be told why).

I understand that if I fail to provide any information requested in this form; or do not agree to any of the possible exchanges or uses detailed above, ACE may be unable to assess the claim.

**To find out what sort of personal information ACE have about you, or to make a request for access, please telephone 1800 815 675.

Medical Authority, Declaration and Power of Attorney

I DECLARE THAT,

- I will use my best endeavours and render all reasonable assistance and co-operation to Ace Insurance Limited (ACE) in the assessment of my claim;
- the information supplied by me is true and correct and that I have not withheld any information likely to affect the acceptance of the claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proofs of my claim; ACE has made not acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy

I hereby appoint ACE to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I hereby authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as ACE in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time)
- my Health Insurance claims history, including Medicare;
- any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

Signature of Claimant

Date

Signature of Claimant

Date

Medical Practitioner's Statement to Company

THE POLICY HOLDER IS RESPONSIBLE FOR ANY FEE FOR THIS STATEMENT
THIS FORM SHOULD BE COMPLETED AND RETURNED TO ACE PROMPTLY

Patients Full Name

Date of Birth

Height

cms

Weight

kgs

Diagnosis (if fracture or dislocation, describe nature and location i.e.: **Simple, Compound**)

Cause:-

If available please provide a copy of X-ray report

Is this condition an injury

Or an illness

Does the patient have any other injury or illness that is contributing to the condition? eg: Osteoporosis

No

Yes

- give details

Is condition due to injury or sickness arising out of the patient's employment

No

Yes

- give details

Was the disability, sports related

No

Yes

- give 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?

No

Yes

- give details

How long have you been the patient's usual doctor / medical practice?

yrs

Date of Admission

Date of Discharge

Has the patient been hospitalised?

Name of Hospital

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated?

No

Yes

- give details

Date performed or anticipated

Give name of hospital?

Did you provide other medical services (including pathology) to the patient?

No

Yes

- itemise, give details

Was the patient referred by you or to you?

No

Yes

- give details

Please provide name and address of referring doctor

Name

Address

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

/ /

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

Hours per week

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?

No

Yes

- give details

Name of Company and Claim No.

Contact Name and Telephone No.

Remarks

Signature of medical practitioner

Name - print

Date

/ /

Qualifications

Address

Telephone Number

Letter of Consent

Full Name of Claimant

Claimants Address

Claimants Date of Birth

Injury Details

Date of Injury

To Whom It May Concern:

I hereby authorise a representative from ACE Insurance Ltd or CSN to obtain personal medical information, if needed, in relation to my current claim as per above noted injury.

Your sincerely,

Signature

Name (please print)