Personal Accident & Sickness

Claim Form

winsure UNDERWRITING

IMPORTANT NOTICES

INSURER AND AGENT

The contract of insurance is arranged by Winsure Underwriting Pty Ltd ('Winsure') (ABN 68 169 336 252, AR No. 459637), an Authorised Representative of SUA Agency Services Pty Ltd (ABN 15 096 726 895, AFSL 234437) acting under a binder as agent for the insurer, certain Underwriters at Lloyd's ('the Insurer').

PRIVACY STATEMENT

In this Privacy Statement the use of 'we', 'us' and 'our' means the Insurer and Winsure unless specified otherwise.

We are committed to the protecting your privacy. We collect, use, storage and disclose personal information in accordance with the Australian Privacy Principles and the *Privacy Act 1988* (Cth).

Winsure's Privacy Policy which is available at www.winsure.com.au or by calling Winsure, sets out how:

- we protect your personal information;
- you may access your personal information;
- you may correct your personal information held by us;
- you may complain about a breach of the *Privacy Act 1988* (Cth) or Australian Privacy Principles or and how we will deal with such a complaint.

We need to collect, use and disclose your personal information (which may include sensitive information such as health information) in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

The primary purpose for our collection and use of your personal information is to enable us to provide insurance services to you.

We may disclose your personal information to third parties who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers, reinsurers and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). Some of these third parties may be located outside of Australia. In all instances where personal information may be disclosed to third parties who may be located overseas, we will take reasonable measures to ensure that the overseas recipient hold and use your personal information in accordance with the consent provided by you and in accordance with our obligations under the *Privacy Act 1988* (Cth).

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insured's). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

Winsure's Privacy Policy contains information about how to access and correct the personal information about you and also how to complain about a breach of privacy. If you would like additional information about privacy or would like to obtain a copy of the Privacy Policy, please contact Winsure's Privacy Officer by:

Address: PO Box A2016, Sydney South NSW 1235
Phone: +61 2 9307 6656
Fax: +61 2 9307 6699
Email: privacyofficer@steadfastagencies.com.au

You can download a copy of Winsure's Privacy Policy by visiting www.winsure.com.au

CONTACT US

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Sections Breakdown

- ☐ **Section One** — To be completed by the claimant
- ☐ **Section Two** — To be completed by the attending physician
- ☐ **Section Three** — To be completed by Principal Contractor/Employer or accountant if applicable

SECTION ONE

Policy Details

Policy Number

Policy Expiry Date — DD / MM / YYYY

Full Name

Given Name

Surname

Address for notices

Number, Street Address

Suburb

State

Postcode

Occupation

Occupation and full title of your position

Duties

Full description of your duties

Age & BMI

Date of Birth — DD / MM / YYYY

Height — cm

Date of Birth — Kg

Medicare

Medicare Number

SECTION ONE (Continued)

Employer

Employer / Principal Contractor

Contact Details

Business Telephone Number

Mobile Phone Number — DD / MM / YYYY

Home Telephone Number

Fax Number

Email Address

INCIDENT DETAILS

Address of Incident

Number, Street Address

Suburb

State

Postcode

Time of Incident

AM / PM
Time of Incident

DD / MM / YYYY
Date of Incident

Witness(es)

Were there any Witnesses to the accident? If "Yes", provide details below. Yes ☐ No ☐

Witness 1

Given Name

Surname

Number, Street Address

Suburb

State

Postcode

Witness 2

Given Name

Surname

Number, Street Address

Suburb

State

Postcode

Circumstances

Please describe the circumstances surrounding the incident.

Injuries

Please describe in full the injuries incurred.

Treatment

Have you been treated previously for any serious injury? If "Yes", please provide details below. Yes ☐ No ☐

PREVIOUS CLAIMS

Details of any claim made against any insurance company for injury or workers compensation

Claim 1

DD / MM / YYYY
From Date

DD / MM / YYYY
To Date

Company Name

Company Address

Claim 1

DD / MM / YYYY
From Date

DD / MM / YYYY
To Date

Company Name

Company Address

SICKNESS

The nature of the Sickness / Illness

When did the Sickness / Illness begin

History

Have you suffered from this complaint before? If "Yes", when, and how long were you disabled? Provide details and dates below. Yes ☐ No ☐

Details of any claim made against any insurance company for injury or workers compensation

Claim 1

DD / MM / YYYY — From Date

DD / MM / YYYY — To Date

Company Name

Company Address

Claim 1

DD / MM / YYYY — From Date

DD / MM / YYYY — To Date

Company Name

Company Address

TREATMENTS

History

Was hospital treatment required? If "Yes", complete below. Yes ☐ No ☐

Hospitals – if you were admitted or treated as an out-patient provide details below.

Hospital Name & Address

DD / MM / YYYY — Date Admitted

DD / MM / YYYY — Date Released

Give details of all attending physicians:

1. Doctor's Name

( ) Contact Number

2. Doctor's Name | Contact Number ( )

3. Doctor's Name | Contact Number ( )

Medical Leave

When did you stop work? DD / MM / YYYY

When did you first receive treatment from a doctor? DD / MM / YYYY

Is this doctor still treating you for the Injury/Sickness? Yes ☐ No ☐

Is this your regular doctor? If "No", Give details of your regular doctor below. Yes ☐ No ☐

Medical Centre

Doctor's Name | Contact Number ( )

Please give details of all doctors consulted in the past 5 years:

Doctor's Name	Medical Centre	Contact Number

Is there any condition (past or present) affecting your current disability? If "Yes", give details below. Yes ☐ No ☐

Current Situation Are you now

Recovered	Yes ☐	No ☐	When did you return to work?	DD / MM / YYYY
Partially Disabled	Yes ☐	No ☐	When did you begin to undertake part normal duties	DD / MM / YYYY
Totally Disabled	Yes ☐	No ☐	When do you expect to return to work	DD / MM / YYYY

Employment

Have you engaged in any other employment since you became disabled, whether paid or not? If "Yes", give details. Yes ☐ No ☐

Have you made or will you make a claim for benefits under any other insurance policy or compensation scheme because of this Injury/Sickness? If "Yes", give details below. Yes ☐ No ☐

Type of Insurance / Scheme	Company Name	Contact	Reference Number

DECLARATION AND SIGNATURE BY CLAIMANT

I,

Print Name In Full

OF

Print full address here

DD / MM / YYYY

Date of Birth

Medicare Number

Hereby authorise Medicare, any hospital, physician or other person who has or will be attending me, any Principal Contractor/employer, to furnish Winsure Underwriting Pty Ltd ABN: 68 169 336 252 or its representatives with any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatments, copies of all hospital or medical records and copies of all records of Principal Contractor/employers.

I am aware and accept that Medicare will provide my full Medicare history since 1984 to Winsure/the Insurer or its representatives. As such, information regarding services and treatments not related to this claim will also be provided. I agree that a Photostat copy of this authorisation shall be considered as effective and valid as the original.

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 future declaration in respect of the said injury or sickness shall make any false or fraudulent statements or in respect of past or future injuries or sickness, all benefits under this policy shall be forfeited.

I consent to Winsure/the Insurer using the personal information (including sensitive information) I/we have provided on this claim form for the purposes of processing my claim. I consent to the disclosure of personal information (including sensitive information) to third parties and overseas where it is reasonably necessary for the processing of my claim. I understand that if this consent is not given Winsure/the Insurer will not be able to process this insurance claim.

NOTE - If someone has completed this form on your behalf, before signing this proposal form double check the details to ensure that you agree to all answers completed by that person are true and correct.

Signed by claimant

Name

Title / Position

Signed

DD / MM / YYYY

Dated

Witnessed By

Name

Title / Position

Signed

DD / MM / YYYY

Dated

SECTION TWO

This section is to be completed by the attending physician

Patient Details

Patients First Name

Patients Surname

Number, Street Address

Suburb

State

Postcode

Practitioner Details

Doctors First Name

Doctors Surname

Medical Centre

Email Address

( )

Phone

How long have you been treating this patient?

Years

Months

Are you the regular practitioner? Yes No

If "No", please give details of regular practitioner:

Doctors Name

Medical Centre / Facility

Diagnosis

When did the patient first receive medical treatment? DD / MM / YYYY

Please give a diagnosis of this condition:

Previous History

When did the patient first receive medical treatment? Yes No

If "Yes", please state condition and advise when previous treatment was given:

ACCIDENT

Incident

When did the patient suffer Injury? DD / MM / YYYY AM / PM

Circumstances

What were the circumstances surrounding the injury?

DEGREE OF DISABILITY

Patients Occupation

Duties

Cessation

When was the patient obliged to cease work? DD / MM / YYYY AM / PM

Is the patient entirely prevented from engaging in normal occupation? Yes ☐ No ☐

If the patient is **still disabled,** when approximately will the patient be able to resume?

DD / MM / YYYY (Full Duties:) DD / MM / YYYY (Light Duties:)

If the patient **has recovered,** when approximately will the patient be able to resume?

DD / MM / YYYY (Full Duties:) DD / MM / YYYY (Light Duties:)

TREATMENT OF PRESENT CONDITION

Consultation

When were you consulted? DD / MM / YYYY (Initially) DD / MM / YYYY (Most Recently)

How often has the patient consulted you?

Was the patient confined to hospital? Yes ☐ No ☐ Hospital

What are the subjective symptoms?

Please give results of any tests, examinations or x-rays etc.:

What Surgical Procedures have been performed?

What surgical procedures are contemplated?

Underlying Conditions

Are there any underlying conditions affecting recovery from the condition? If "Yes", give details below. Yes ☐ No ☐

Impairment

Has the patient any other physical or mental impairment? If "Yes", give details below. Yes ☐ No ☐

TREATMENT OF PRESENT CONDITION (Continued)

Treating Physicians Please advise names and speciality of other treating physicians:

Physician 1

Physician 2

Physician 3

Have you terminated treatment? Yes ☐ No ☐ DD / MM / YYYY

Prognosis
What is the current prognosis?

Remarks
Are there any further remarks which may assist in assessing this condition?

Permanent Disability
Is there any permanent disability at present? If "Yes", provide details below. Yes ☐ No ☐

SIGNATURE BY PHYSICIAN

Signature

DD / MM / YYYY
Dated

Degree

Qualification

Hospital / Clinic

SECTION THREE

This section is to be completed by the Principal Contractor / Employer or Accountant (if applicable)

1. If Self-employed (other than as part of a group plan)

Accountant Details

Accountancy Firm & Contact Person

Number, Street Address

Suburb | State | Postcode

Email

Phone Number | Fax Line

2. If Employed

Employer's Details

Employer / Principals Name

Number, Street Address

Suburb | State | Postcode

Email

Phone Number | Fax Line

The employee has been incapacitated since DD / MM / YYYY The employee is expected to/did resume duties on DD / MM / YYYY

The employee's average earnings six months prior to the date of Injury / Sickness $

During the period of incapacity the employee received:

Normal Pay	$	From	DD / MM / YYYY	To	DD / MM / YYYY
Sick Pay	$	From	DD / MM / YYYY	To	DD / MM / YYYY
Workers Compensation	$	From	DD / MM / YYYY	To	DD / MM / YYYY
Other (specify)	$	From	DD / MM / YYYY	To	DD / MM / YYYY

To what date will you be continuing to deduct Personal Accident and Sickness premiums? DD / MM / YYYY

I hereby certify that the Claimant has been unable to attend their usual occupation with the company as a result of Injury / Sickness.

Full name of Employer's Representative | Position within the company

Signature of Employer's Representative | DD / MM / YYYY