



Accident/Illness Claim

The issue of this form does not constitute an admission of liability on the part of the insurer. Please complete all sections.

Policy No.

Claim No.

Insured Details											
Insured	Surname					Given Name(s)					
Claimant	Surname					Given Name(s)					
Are you registered for GST?		No <input type="checkbox"/>		Yes <input type="checkbox"/>		What is your ABN?		<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Are you entitled to claim an input tax credit on the GST component of the premium applicable to this Policy?		No <input type="checkbox"/>		Yes <input type="checkbox"/>		– Are you entitled to claim an amount less than 100%?					
		No <input type="checkbox"/>		Yes <input type="checkbox"/>		– Specify amount claimed		%		<input type="text"/>	
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?		No <input type="checkbox"/>		Yes <input type="checkbox"/>		– Are you entitled to claim an amount less than 100%?					
		No <input type="checkbox"/>		Yes <input type="checkbox"/>		– Specify amount claimed		%		<input type="text"/>	
Address							State		Postcode		<input type="text"/>
		Home		()			Work		()		
Contact Numbers		Mobile					Email				
		Date of Birth		/ /		Height		cm		Weight	
Sex		Male <input type="checkbox"/>		Female <input type="checkbox"/>							
Occupation					Describe your usual duties						

Injury/Illness Details													
1. Give a full description below of injury or illness for which you are claiming.													
Illness	Condition												
	When did it commence?												
Injury	How were you injured?												
	What injuries did you receive?												
	What were you doing when you were injured?												
	Where did the accident occur?												
	Details of person who witnessed the accident.					Surname					Given Name(s)		
	Address					State		Postcode					
	Telephone number					()							
Did the injury occur during the course of your usual occupation?										Yes <input type="checkbox"/>		No <input type="checkbox"/>	
If the injury resulted from a motor vehicle accident were you required to undergo a breath analysis or blood test?										Yes <input type="checkbox"/>		No <input type="checkbox"/>	
If Yes, attach a copy of analysis result.													

Injury/Illness Details (continued)

2. Have you ever had this, or similar condition, in the past? Yes No
 If Yes, give details.

Condition	
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Treated by?		Date	/ /
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3. Give the exact date when illness began, or injury occurred. Date / / Time am/pm

4. When did you first consult a doctor for this condition? Date / / Time am/pm

5. When did you become totally disabled (unable to work)? Date / / Time am/pm

6. If still disabled, when do you expect to return to work? Date / / Time am/pm

7. If you have returned to work, when were you able to again perform:

• one or more of the material tasks of your occupation? Date / /

• all the tasks of your occupation? Date / /

8. If you were admitted to a hospital, or treated as an outpatient, please give details below.

Name of hospital	Address	From	To	In/Out patient
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

9. Details of all attending physicians.

Doctor's name	Address	Telephone number
		()
		()
		()

10. Who is your usual family doctor?

Doctor's name	Address	Telephone number
		()

How long have you been receiving treatment or advice from this doctor? years months

11. What other medical or surgical treatment has been received during the past 5 years?

Date	Nature of treatment	Doctor's name	Address
/ /			
/ /			
/ /			
/ /			

12. Are you now, or have you ever been, subject to or affected by any other injury, disease, deformity, defect of senses, infirmity or weakness? If Yes, give details. Yes No

Injury/Illness Details (continued)

13. Have you ever lodged a personal accident or illness claim before? Yes No
If Yes, give details.

14. Are you making or entitled to make any other insurance or compensation claim in respect of this disability?
Sick leave Yes No Motor compensation Yes No Other government benefits Yes No
Workers' compensation Yes No Private health fund Yes No Superannuation life insurance Yes No

Name of fund(s)/insurance company

15. Name of previous employers over last 5 years

Name of employers	Period	
	From	To
	/ /	/ /
	/ /	/ /
	/ /	/ /

IMPORTANT: Attached is an attending physician's statement for your doctor to complete. Your claim cannot be processed until we receive your completed claim together with the attending physicians statement. We will also require medical certificates each month from the date of disablement and a final certificate showing the actual date you resumed work.

Declaration of Earnings

IMPORTANT INFORMATION

- If you are self-employed, Weekly Earnings means your weekly earnings derived from personal exertion after allowing for the cost and expenses in incurring that income. Please complete Section 1.
- If you are not self-employed, Weekly Earnings means your weekly remuneration earned from personal exertion by way of salary, fees, wages, commissions and any other items already agreed by us. Please complete Section 2.
- You may be required to supply proof of your income by submitting copies of your personal and/or business income tax returns for the full financial year immediately preceding the injury or illness for which you are now claiming.

SECTION 1 – SELF EMPLOYED PERSONS (To be completed by your accountant.)

Business/Trading name			
Address			
	State		Postcode

Was the business fully operational and was the Insured fully employed at the time of suffering the accident or contracting the illness? No Yes – give details

Does the business have Workers' Compensation Insurance? Yes No

Please state the current weekly earnings (see Important Information 1 above). \$

Accountant's name Signature

SECTION 2 – EMPLOYED PERSONS (To be completed by employer.)

Business /Trading Name			
Address			
	State		Postcode

Please state the current weekly earnings (see Important Information 2 above). \$

Is the insured person entitled to Workers' Compensation benefits? No Yes – give details of payments

a) Weekly rate \$

b) Monies paid to date \$

Declaration of Earnings (continued)						
Was the insured person in your employ at the time of suffering the injury or illness?					Yes <input type="checkbox"/>	No <input type="checkbox"/>
Is the insured person entitled to receive sick leave?			No <input type="checkbox"/>	Yes <input type="checkbox"/>	number of days entitled	days
Has the insured person received any sick leave payments in respect of the injury or illness for which he/she is claiming?			No <input type="checkbox"/>	Yes <input type="checkbox"/>	number of days	days
Please advise the insured person's gross salary at the date of injury or illness.					\$	
Officer's name				Position		
Telephone number	()	Signature			Date	/ /

Payment Methods (Please note we are not liable for any bank processing fees on the receiver side)							
1.	Australian bank account			Provide details below <input type="checkbox"/>	Deposit slip provided <input type="checkbox"/>		
	Bank name			Account name			
	BSB			Account number			
2.	Australian dollar cheque mailed to address above (please provide alternate address on separate sheet if required)				<input type="checkbox"/>		
3.	Payment to Australian credit card			Mastercard <input type="checkbox"/>	Visa <input type="checkbox"/>	Amex <input type="checkbox"/>	
	Issuing bank			Cardholder's name			
	Card number					Expiry date	/ /
4.	Foreign currency draft to address above <input type="checkbox"/>			Currency	<input type="checkbox"/>		
	(please advise if other address is required)			(note: certain currencies are not available)			
5.	Foreign currency telegraphic transfer (all bank details must be completed below - attach separate sheets if necessary)				<input type="checkbox"/>		
	Bank name			Currency required			
	Bank address						
	Account holder's full name						
	Account number			Swift code/Sorting code/Routing Number/BAN/BA			

Privacy

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our website www.qbe.com.au or contact the Compliance Manager on 02 9375 4656 or email compliance.manager@qbe.com for further information.

Declaration and Authorisation	
The information and answers given above are true, correct and complete in every detail.	
1. I/We understand the claim may be refused if information is not true or is withheld.	
2. I/We authorise QBE Insurance (Australia) Limited to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.	
Medical Authority: I authorise any hospital, physician or other person who attended me, to give QBE Insurance (Australia) Limited or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.	
A photocopy of this authorisation will be considered as effective and valid as the original.	
Signature of Insured 1.	X <input type="text"/> Date <input type="text"/> / /
Signature of Insured 2.	X <input type="text"/> Date <input type="text"/> / /

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM.
Return the completed form to your Financial Services Provider or mail to QBE Insurance, GPO Box 4229, Sydney NSW 2001.



Attending Physician's Statement

Any charge for this statement must be borne by the patient.
Please complete all sections.

Policy Number

Claim Number

Important – your doctor must complete the attending physician's statement. Your claim cannot be processed until we receive your completed claim together with the attending physician's statement.

Patient's Details										
Patient's name (block letters)	Surname					Given Name(s)				
Address						State			Postcode	
	Date of Birth	/	/	Height	cm	Weight	kgs	Sex	Male <input type="checkbox"/>	Female <input type="checkbox"/>
Occupation										

History		
When did the patient first receive medical treatment?	Date	/ /
Was there a previous history of this or a similar condition?	No <input type="checkbox"/>	Yes <input type="checkbox"/> – Advise when treatment was given

Condition
Please give a complete diagnosis of this condition.

If Injury			
When did the patient suffer the injury?	Date	/ /	Time
What did the patient tell you were the circumstances surrounding the injury?			

If Illness			
When was the illness first contracted?	Date	/ /	Time
When did the symptoms become evident?	Date	/ /	Time

Degree of Disability			
When was the patient obliged to cease work?	Date	/ /	Time
If the patient is still disabled, when will the patient be able to resume:			
• one or more of the material tasks of his/her occupation?	Date	/ /	
• all of the tasks of his/her occupation?	Date	/ /	
If the patient has recovered, when was the patient able to resume:			
• one or more of the material tasks of his/her occupation?	Date	/ /	
• all of the tasks of his/her occupation?	Date	/ /	

A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK.

Treatment of Present Condition						
When were you first consulted?					Date	/ /
When were you last consulted?					Date	/ /
How often has the patient consulted you?						times
Was the patient confined to hospital?					No <input type="checkbox"/> Yes <input type="checkbox"/> – Give details	
Name of hospital	Address	Period of confinement				
		From		To		
		/ /	/ /			
		/ /	/ /			
What are the current subjective symptoms?						
Please give results of any objective findings						
X-rays						
Other tests						
What surgical procedures have been performed or are being contemplated?						
Is there any underlying condition affecting recovery from the current condition?					No <input type="checkbox"/> Yes <input type="checkbox"/>	
– If Yes, advise nature of underlying condition and how it affects disability and recovery.						
Please advise names and addresses of other treating physicians.						
Do you believe rehabilitation would benefit this patient?					No <input type="checkbox"/> Yes <input type="checkbox"/>	
Have you terminated treatment?					No <input type="checkbox"/> Yes <input type="checkbox"/> – Advise date	
					/ /	
What is the current prognosis?						
Are there any further remarks which may assist in assessing this condition?						
Doctor's name		Qualifications				
Address				State		Postcode
Telephone no.		()				
Signature		X		Date	/ /	