

AFA Claim Form

This is the form to use when making a claim on any policy provided by AFA Pty Ltd, AFS Licence No 247122.

Correct completion of these forms will assist us to make accurate and faster decisions regarding our customers' claim for benefits and ensure that where benefits are payable that they reach our customers in a timely manner. Incomplete claim forms will be returned for completion, leading to assessment delays.

Please remember that premium payments are not waived when you make a claim and you must continue to pay the premium whilst you are claiming benefits

IMPORTANT NOTE

There are **three** sections to this claim form

Sections one, two and three must be completed in all cases.

Section one: **CLAIMANT CERTIFICATION** is to be completed by the person making the claim (the sick or injured person)

Section two: **MEDICAL CERTIFICATION** is to be completed by the registered medical practitioner who is/or has been involved in treating the person making the claim (ANY FEE INCURRED FOR COMPLETION OF THIS FORM BY THE DOCTOR IS THE RESPONSIBILITY OF THE PERSON MAKING THE CLAIM)

Section three: **FINANCIAL CERTIFICATION** is to be completed by the person making the claim or their employer (see instructions in that section)

NOTE: This form is used to initiate a claim – if you continue to be disabled you will be sent further progress forms for completion and return on a regular basis.

ELECTRONIC FUNDS TRANSFER FORM (EFT) for Claim Payments

Important: Should your claim be accepted & benefits are payable we will require your account details.

Please be sure to complete the following section so that payments can be processed.

Claimant's name

Name of Bank/Credit Union:

BSB Number (6-digit number):

Account Name:

Account Number

I authorise AFA Pty Ltd to directly credit claim benefits to my account as noted above.

Signature of Claimant Authorising EFT benefits:

Date:

Note: Providing your account details above does not mean that your claim is acceptable and qualify you for benefits. This form is used to initiate a claim only.

SECTION 1 Claimant Certification To be completed by the person making the claim (the injured or sick person)

Policy No

1.1 Your details

First name

Surname

Date of birth

 / /

Full address (Note: we do not accept post office boxes as your address) Number and street

Suburb/town

State

Postcode

Address for correspondence (if different) Number and street

Suburb/town

State

Postcode

Contact number during business hours

 ()

After hours number

 ()

Mobile number

Email address

1.2 Details of your occupation

What is your occupation?

How many years have you been in this occupation?

 years

How many hours do you work per week?

 hours

When did you join your current employer or start operating your business?

 / /

List here all the duties of your occupation and the average time (percentage) you perform each duty per week

Percentage of time doing, and type of, sedentary/light duties	Percentage of time doing, and type of, manual duties
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

How long have you been performing the duties listed above? years

In what occupations have you worked?

from to (years)

Which of the following are you? (please tick)

a) An employee ... By whom are you employed/or for whom do you work? (business or company name)

Employer's address

State

Postcode

b) Self employed ... What is your business structure? (eg. Sole trader/ partnership/company)

Do you have any employees?

No Yes If so, how many

If you are/have been unable to work in your business because of sickness or injury, have your employees continued to work in your absence?

No Yes

What percentage of business expenses if any is your partner (or other person) responsible for? %

c) A contractor

d) A subcontractor

e) Other ...

Please provide details here

1.3 Details of the injury claimed Complete this section only if you are claiming for an injury caused by an accident.

If you are claiming for a sickness then you need to complete Section 1.4 on page 4.

1. If you were injured, what is the **injury**?
2. If you were injured, please describe fully how the **injury** occurred
3. If you were injured, what is the street address where you were **injured**?
 Suburb/town State Postcode
4. If you were injured, were you working, or at work, at the time of the **injury**?
5. If you were injured, were you travelling to, or from, work at the time of the **injury**? No Yes
6. If you were injured, what were you actually doing at the time you were **injured**?
7. When did you **first** see a doctor for the injury and who was the doctor you first saw?
Dr. on / /
8. If you were injured please tell us the time it happened AM/PM on / /
9. Nominate the names and addresses of two witnesses who saw you injure yourself
Witness 1: Name
Address
Suburb/town State Postcode
Contact number ()
Witness 2: Name
Address
Suburb/town State Postcode
Contact number ()
10. Did you cease all duties as a result of this injury?
No Yes On what date? / /
11. Is this **the first time you have EVER injured** this part of your body?
Yes No If no, please answer question 13
12. If you have **EVER previously injured this part of your body** please advise the date it happened, the nature of the injury and how it occurred
13. Which doctor, hospital or medical centre, if any, did you consult **the previous time** you injured yourself?
I previously saw Doctor (their name) for injury to this part of my body on (the date) / /
14. Are you entitled to, and/or have you now made, or intend to make, a claim for benefits of any type in regard to injury to this part of your body? (eg, worker's compensation, public liability, compulsory third party motor vehicle insurance, Centrelink, other insurer, etc)
No Yes If so, provide full details ... Claim made on / /
Claim made against (organisation) Policy number
Indicate the outcome of the claim here (eg, accepted, paid, declined, amount paid etc)
15. Are you in receipt of any wages, salary, paid sick leave or income from any other source?
No Yes If so, please provide details
16. Have you returned to work **in any capacity** yet?
No Yes full time capacity part time capacity
If so, please state the date on which you first returned here / /
17. If you have NOT yet returned to work, when do YOU expect that you will be able to do so?
 / /

more questions overleaf..

1.4 Details of the sickness claim Complete this page only if you are claiming for a sickness

If you are claiming for an injury then you need to complete section 1.3 page 3

1. If you have/or had a sickness, what is the **sickness**?

2. If you have/or had a **sickness** when did you first experience the symptoms?

 / /

3. What were the symptoms of the **sickness** that you first experienced?

4. Was your **sickness** caused, or contributed to, by work?

No Yes If so, how?

5. Did the **sickness** cause you to **completely cease work**?

No Yes

6. If the **sickness** caused you to **completely cease work**, on what date did you completely cease work?

 / /

7. When did you **first** see a doctor for the sickness, and who was the doctor you first saw?

Doctor on / /

8. Have you **EVER** had this **sickness, symptoms of this sickness, or a similar sickness** before the period for which you are currently claiming?

No Yes If yes, please describe the nature of the sickness, when it occurred and how long it lasted.

9. If you have **EVER** had medical advice or treatment for this **sickness or a similar sickness, or similar symptoms**, before the period for which you are currently claiming, from whom and when did you obtain the advice or treatment?

I previously had medical advice or treatment for this sickness, or a similar sickness, or similar symptoms on / /

The following doctor, medical practice or hospital provided advice/treatment;

10. Are you entitled to, and/or have you now made or intend to make, a claim for benefits of any type (eg. worker's compensation, public liability, compulsory third party motor vehicle insurance, Centrelink, other insurer, etc) in regard to this sickness, or a similar sickness or symptoms?

No Yes If so, provide full details here.

Claim made on (date)

 / /

Claim made against (organisation)

Policy number

Indicate the outcome of the claim here (eg. accepted, paid, declined, amount paid etc)

11. Are you in receipt of any wages, salary, paid sick leave or income from any other source?

No Yes If so, please provide details.

12. Have you returned to work in any capacity yet?

No Yes If so, please state the date on which you first returned here / /

full time capacity

part time capacity

13. If you have not yet returned to work, when do YOU expect that you will be able to do so?

 / /

14. If you have not yet returned to work, how is the sickness currently preventing you from working?

1.5 Your medical treatment

1. Were you admitted to hospital?

No

Yes

If admitted, which hospital were you admitted to? (please attach a copy of the hospital admission or discharge summary)

2. On what date were you admitted to hospital? / /

On what date were you released? / /

3. Is the doctor that you have been seeing for your injury or sickness your usual treating doctor?

Yes

No

If not, how long have you been seeing this current doctor? days months years

4. Who is your usual treating doctor and what is the address of their practice?

Doctor's name

Telephone number

 ()

Full address of practice

Suburb/town

Postcode

State

Contact number

 ()

5. Have you been referred to a specialist?

No

Yes

Please provide the names and addresses of specialists you have been referred to.

Specialist 1: Name

Address

Suburb/town

Postcode

State

Contact number

 ()

6. If you have been referred to a specialist are you still consulting the specialist?

No

Yes

7. What tests have you undergone (for example CT scan, MEI, blood) and when? Please attach copies.

Date	Tests

8. What medical treatment, including medication and therapies are you currently receiving and how frequently?

1.6 Declaration and Information Authorities

I understand that AFA Pty Ltd (ABN 83 067 084 333) and (AFS License No. 247122) may need to access, collect and disclose information about me in order to be able to assess my claim for benefits. In order to do so, I (insert your full name here)

of (your address)

Suburb/town

Postcode

State

hereby authorise AFA Pty Ltd to collect and disclose information about me from and to the Health Insurance Commission, any insurance company, Centrelink, any hospital, physician, medical practice, any medical services provider, any medical therapy provider, any past or present employer, investigators, insurance reference bureau, financial institutions including banks, the Taxation Department or my accountant with respect to any sickness, injury, medical history, consultation, treatment including prescription of medication, copies of hospital medical records and tests and reports, medical practice records, vocational and employment records from past and present employers, copies of accounts and accountants statements including my taxation returns and assessments.

In providing or obtaining information about me, I understand that AFA Pty Ltd will use that information in the assessment of my claim, and that if I do not provide, or permit access to this information my claim may not be able to be assessed by AFA Pty Ltd.

AFA Pty Ltd, may also collect and disclose information about me to:-

- Its relevant staff and contractors and service vendors involved in delivering services on behalf of AFA Pty Ltd.
- An agent or broker who collects the claim form from me, or who otherwise assists in facilitating the assessment of my claim
- Its re-insurers, or re-insurance brokers (which may include re-insurers or re-insurance brokers located outside Australia)
- Its legal service providers such as legal firms, or to accountants, actuaries, providers of medico-legal services, loss adjusters, auditors, Financial Ombudsman Service (FOS) and claims management consultants.

By completing and returning this form to AFA Pty Ltd, I agree to AFA Pty Ltd collecting additional information from the parties specified above in connection with the assessment of my claim and agree to AFA Pty Ltd using and disclosing my information as set out above.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving AFA Pty Ltd, notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I have made any false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that all benefits under this policy shall be forfeited.

Signature

Date

 / /

Section 2 Medical certification

This part of the claim form *must* be completed by a *registered doctor* who is certifying that the injured or sick person is, or was, disabled from working.

Please note that any fee incurred for the completion of this medical certification form is the responsibility of the patient.

Please note that medical certification is not accepted prior to the date you have first been consulted for this medical condition.

2.1 Patient's details

First name

Surname

Date of birth

 / /

Male

Female

Full address (Note: we do not accept post office boxes as the address) Number and street

Suburb/town

State

Postcode

1. How long has the patient been known at your practice? years

2. Are you the patient's primary treating physician at your practice?

Yes

No

If not, please provide details of the physician who is

3. What do you understand the duties of the patient's occupation/business to be?

4. What percentage of the patient's duties are sedentary?

5. What is the clinical medical diagnosis for which the patient is claiming to be disabled from working?

6. What are the reported symptoms?

7. When did these symptoms first manifest?

8. What are the current symptoms?

9. When did the patient first consult you in regard to this period of disability?

 / /

10. When was the diagnosis reached?

 / /

11. **Was there any previous history of this or of a similar condition?**

No

Yes

If so, please provide full details of the dates and the nature of the previous history of the injury or sickness

12. If the patient sustained an injury, what were the circumstances of the injury?

13. If this condition is not related to an injury, what is the cause of the patient's disability?

14. On what date did the injury/accident occur?

 / /

more questions overleaf..

2.2 Specifics of disability

1. On page 2 section 1.2 of this claim form, the patient has provided a breakdown of their occupational duties and the percentage of time spent engaged in each duty per week.

In consideration of these duties and hours, please provide the following information.

1.1 Has the patient been **ENTIRELY PREVENTED** from engaging in their occupation by the medical condition?

No Yes If so, from what date / /
to what date / /

1.2. Has the patient **ONLY BEEN PARTIALLY PREVENTED** from engaging in their occupation by the medical condition?

No Yes If so, from what date / /
to what date / /

1.3. Is the patient now capable of a return to **FULLTIME** duties?

No Yes If so, from what date / /

1.4. Is the patient now capable of a return to **PARTIAL DUTIES**?

No Yes If so, from what date / /

2. If the patient is not yet capable of returning to **FULLTIME DUTIES**, what is currently preventing them from doing so?

3. If the patient is not yet capable of returning to **PARTIAL DUTIES**, what is currently preventing them from doing so?

4. What duties of their occupation could the patient currently perform and for how many hours per week?

Duty

for hours per week

5. Please list here details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis. (Please attach copies.)

Date	Tests

Conducted by

Result

6. Has the patient been referred to a specialist?

No Yes Please provide name and contact details of the specialist

7. What is the current regime of medical treatment?(medication, therapies, surgery etc)

8. Are there any concurrent conditions, which are affecting the patient's ability to return to work? (eg, depression/anxiety)

No Yes Please state what the concurrent condition is and to what degree it prevents/restricts the patient returning to their occupation

9. Are there any other non-medical factors (eg work imposed barriers) affecting the patient's ability to work?

No Yes Please provide details

2.2 Specifics of disability continued

10. Are you providing information in respect of this patient to any other insurer?

No

Yes

If so, which insurer?

11. Did you examine this patient before completing this form?

No

Yes

Please provide details

Doctor's declaration

The information provided in this medical certification is a truthful, comprehensive and frank account of the patient's medical condition, medical history and level of disability. I understand that if I have provided any false or misleading information in this medical certification, or if I have deliberately omitted information from this medical certification which has been requested and which I am able to give, it may result in a report to the Medical Registration Board or further action by the insurer, including civil action to recover compensation paid to the claimant in circumstances where reliance was placed on the accuracy and genuineness of the information I have provided.

Signature

Date

 / /

Name

Qualifications

Practice address (Note: we do not accept post office boxes as your address) Number and street

Suburb/town

State

Postcode

Telephone number

()

more questions overleaf..

Section 3 Financial certification

IMPORTANT INSTRUCTIONS

1. If you are **SELF EMPLOYED** you must complete the first section on this page. You **MUST** provide a copy of your entire Individual Taxation Return & Notice of Assessment for the financial year immediately prior to your ceasing work due to your Injury or Sickness and if you are a company/partnership please also provide a copy of your entire Business Taxation Return. If you operate a Trust as part of your business structure you must also include a full copy of the entire Trust Taxation Return.
2. If you are an **EMPLOYEE, CONTRACTOR** or **SUB-CONTRACTOR**, your employer or principal contractor must complete the second section on page 11. Acceptable proof of income includes a copy of your entire Individual Taxation Return AND Notice of Assessment for the financial year immediately prior to your ceasing work due to your Injury or Sickness.
3. Claims which are not accompanied by the proof of income as requested above, **CANNOT BE ASSESSED**.

1. Self employed

If you are self employed, you must complete this section

Business/company name

ABN

Full address from which the business/company operates

Suburb/town

State

Postcode

What activity principally generated your income in the 12 mths before you ceased work due to injury or sickness?

Have you changed your occupation in the 12 mths before you ceased work due to injury or sickness?

No

Yes

If so, please tell us what your occupation has changed from

to

on / /

Was any of the income you earned in the 12 mths before you ceased work due to injury or sickness split with a spouse or partner?

No

Yes

If so, please provide the percentage %

Your Accountants' Name

Full address from which the business/company operates

Suburb/town

State

Postcode

Accountants' office telephone number

()

Did you/your accountant complete and lodge a taxation return for both of the last two financial years? No Yes

2. An employee

If you are an **EMPLOYEE, CONTRACTOR OR SUBCONTRACTOR** your employer or principal contractor must complete this section

I hereby certify that (name of sick or injured person)

has been engaged/employed by the company/business since the date of _____ in the position of _____

 / /

2.1 Did the person **ENTIRELY CEASE WORK** in their employment position?

No

Yes

If so, from what date

 / /

to what date

 / /

2.2 Did the person **ONLY PARTIALLY CEASE WORK** in their employment position?

No

Yes

If so, from what date

 / /

to what date

 / /

2.3 Has the patient now returned to **FULLTIME** duties?

No

Yes

If so, from what date

 / /

2.4 Has the patient now returned to **PARTIAL DUTIES**?

No

Yes

If so, from what date

 / /

Are there light or partial duties available within the company/business in which the person can work?

No

Yes

If so, please state what duties are available and what hours the person could be alternatively engaged by the company/business

During the period of incapacity did the claimant receive any of the following: -

Paid sick leave from / / to / / in the amount of \$ per week

Paid annual leave from / / to / / in the amount of \$ per week

Workers comp. from / / to / / in the amount of \$ per week

Other: Provide details

from / / to / / in the amount of \$ per week

Signature

Date

 / /

Name

Role (eg Supervisor/paymaster/human resources manager/owner/ manager)

Company/business name

Full address (Note: we do not accept post office boxes as the address) Number and street

Suburb/town

State

Postcode

Telephone Number

Fax Number

Please attach pay advices for the 12 months prior to the employee's disability

Once the claim form has been completed, signed and dated please send it, along WITH ATTACHMENTS, to:-

AFA CLAIMS DEPARTMENT
PO Box R1852
Royal Exchange NSW 1225

OR TO

YOUR
INSURANCE
BROKER

or email it to: enquiries@afainsurance.com

If you have any questions, or if you need assistance with understanding or completing this form, you can contact us on (toll-free) 1300 728 997. Please ensure that you keep copies of all documentation sent to AFA.

End of form. Thank you.