



Insurance Brokers Pty Ltd

Accident And/Or Sickness Claim Form

Please forward this completed form to:

**Claims Department
JUA Underwriting Agency Pty Ltd
Locked Bag 11
ROYAL EXCHANGE POST OFFICE
NSW 1225**

Policy underwritten by certain Underwriters at Lloyd's of London under Austerity held
by
JUA Underwriting Agency Pty Ltd ABN 70 004 566 465

PERSONAL ACCIDENT & SICKNESS CLAIM FORM

IMPORTANT INFORMATION

Please complete all questions and send this form to us to enable us to promptly process your claim. If there is insufficient space on this form to provide your answers, please attach a separate paper.

Your claim cannot be processed until:

- You have fully completed the claim form, signed the declaration and provided any supporting documentation that may be required;
- We receive medical statements about your condition if they are required;

We subscribe to the General Insurance Code of Practice that sets the standards of practice and service for the insurance industry. It is our aim to provide a quality service to you, our customer. In the event we do not achieve our aim and cannot resolve the matter with you, we have dispute resolution process that you can access. Full details appear in the policy document under Code of Practice.

PRIVACY STATEMENT

Lloyd's and its agents are bound by the obligations of the Privacy Act 1988 as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act) This sets out basic standards relating to the collection, use, disclosure and handling of personal information.

"Personal information" is essentially information or an opinion about a living individual whose identity is apparent or can reasonably be ascertained from the information or opinion.

Information will be obtained from individuals directly where possible. Sometimes it may be collected indirectly (e.g. from your representatives)

Only information necessary for the arrangement and administration of Lloyd's business by Lloyd's, its agents and their representatives will be collected. This includes information necessary to accept the risk, to assess a claim, to determine competitive and appropriate premiums, etc.

Lloyd's and its agents disclose personal information to third parties who they believe are necessary to assist them in doing the above. These parties will only use the personal information for the purposes we provided it to them for (or if required by law).

When you give Lloyd's and its agents personal information about other individuals, we rely on you to have made or make 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.

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by Lloyd's by contacting: - JUA Underwriting Agency Pty Ltd on (02) 8272 4800.

SECTION A – PERSONAL DETAILS

| | | | | |
|---------------------|---------|--------|---------------|----------|
| Claimant's Name | Surname | | Given Name(s) | |
| Home Address | | | | |
| Suburb | | State | | Postcode |
| Telephone | Home | | Mobile | |
| Email | | | | |
| Date of Birth | | Height | cm | Weight |
| | | | | kg |
| Employer | | | | |
| Occupation | | | | |
| Payroll / ID Number | | | | |

| | | | |
|------------------------|--|-----|--|
| CLAIM PAYMENTS | Upon acceptance of your claim benefit payments will be paid direct into your Account (unless advised otherwise). Financial Institution details as follows: | | |
| Bank | | | |
| Account Number | | BSB | |
| Account Holder Name(s) | | | |

STATEMENT OF CLAIM

IF A CLAIM FOR SICKNESS – PLEASE GO TO NEXT PAGE

ACCIDENT CLAIM

| | | | | |
|--|--|--|--|----------------------|
| Date of your Accident | | Time | | AM or PM (circle) |
| Full details of the Accident and the Injury sustained | | | | |
| | | | | |
| | | | | |
| First Day you were unable to work | | Date returned to work OR expected date | | |
| Name of Witness (if any) to the Accident | | | | |

| SICKNESS CLAIM (Statement of Claim cont.) | | | |
|--|--|---|--|
| Date you first became aware of your sickness | | | |
| First Day you were unable to work | | Date returned to work OR expected date | |
| Full details of your Sickness and treatment involved | | | |
| | | | |
| | | | |
| | | | |
| Have you ever suffered from this condition in the past? If Yes, please provide full details. | | | |

| PHYSICIAN DETAILS | | | | | |
|--|------|-------|--|------------------|--|
| Details of your usual doctor | Name | | | Telephone Number | |
| Address | | | | | |
| Suburb | | State | | Postcode | |
| Details of the first doctor consulted | Name | | | Date Treated | |
| Address | | | | Postcode | |
| Details of all other attending physicians and/or hospitals | | | | | |
| Name | | | | Date Treated | |
| Address | | | | Postcode | |
| Name | | | | Date Treated | |
| Address | | | | Postcode | |
| Name | | | | Date Treated | |
| Address | | | | Postcode | |
| Details of future treatment e.g. (Surgery, physiotherapy) | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

| MEDICAL AND CLAIMS HISTORY | | | |
|--|--|----|-------------------|
| Are you making or entitled to make a claim under : | | | |
| Workers' Compensation | Yes <input type="checkbox"/> <input type="checkbox"/> | No | Motor Vehicle Act |
| Other Government Benefits | Yes <input type="checkbox"/> <input type="checkbox"/> | No | Other |
| If "Yes" to any of the above, full details | | | |
| What (if any) other claims have you ever made under an Accident & Sickness Insurance Policy? | | | |
| Are you insured elsewhere under an Accident & Sickness Insurance Policy? | | | |
| If Yes, full details | | | |
| Have you engaged in any other income earning employment since becoming disabled? | | | |
| If Yes, full details | | | |

| DECLARATIONS & MEDICAL AUTHORISATIONS | |
|--|-------------|
| <ul style="list-style-type: none"> ▪ I solemnly and sincerely DECLARE that the information given by me in this claim is true and complete. ▪ I AGREE to supply any further information that may be requested of me in connection with my claim. ▪ I AUTHORISE any Doctor, Dentist, Physiotherapist, Company, Firm or person to disclose to JUA Underwriting Agency Pty Ltd (JUA) any and all information that they may request in connection with this claim. ▪ I AGREE that a photocopy of this Authorisation shall be considered to be effective and valid as the original. ▪ I have read and accept the Privacy Statement provided with this claim form. | |
| _____ | _____ |
| Signature | Date |
| Print Name | |
| _____ | _____ |

SECTION B – DOCTORS STATEMENT

| The Patient is responsible for any fee charged to complete this Statement | |
|--|--|
| Claimant's Name | |
| How long has the claimant been your patient or, a patient of this practice? | |
| What date were you first consulted by the patient in connection with the present Injury or Sickness? | |
| How long has the patient been experiencing symptoms before consulting you for the first time? | |
| Exact nature of Injury or Sickness | |
| | |
| If an Injury, please advise the circumstances surrounding the accident, if made aware | |
| | |
| Is the current condition in any way related to work? | |
| If Yes, would you support a Workers' Compensation Claim? | |
| Details of all treatment and/or hospitalisation | |
| | |
| Please enclose results of any tests performed | |
| Details of all proposed treatment | |
| | |
| Has the patient previously suffered from the same or similar condition? | |
| If Yes, full details, including dates of consultations | |
| | |
| Is there anything in the patient's history which may have contributed directly or indirectly, to the Injury or Sickness? | |
| If Yes, full details | |
| | |
| Have you referred the patient for other services and/or specialist treatment? | |
| If Yes, full details | |
| | |

| | | | |
|---|--|---|----------|
| Has the patient continued to follow medical advice? | | | |
| When was the patient obliged to cease work? | | | |
| When do you expect the patient to resume work? | | | |
| If able to resume work in a reduced capacity, when would you expect this to be? | | | |
| I hereby certify that the patient will be totally disabled from following his/her usual duties | | | |
| From / / | | To / / (inclusive) | |
| Additional remarks and prognosis: | | | |
| | | | |
| | | | |
| Doctor's contact details | | Name | |
| Address | | | |
| Suburb | | State | Postcode |
| Telephone Number | | Fax Number | |

I hereby certify that I have personally examined the above named claimant and that in my opinion the statements made in the **Statement of Claim** section of this Claim Form are consistent with the Claimant's Injury or Sickness. I have read and accept the **Privacy Statement** provided with this claim form.

Signature: _____

Qualifications: _____

Date: _____

SECTION C – EMPLOYER OR PRINCIPAL CONTRACTOR STATEMENT

| | | | | | |
|---|----|---------|---|----------|------|
| Claimant Name | | | | | |
| First day not at work | | | | | |
| Date of employment with the Company | | | | | |
| Gross Weekly Earnings averaged over the last 12 months prior to the date of disablement | | | | | |
| Is there a Workers' Compensation Claim lodged or to be lodged? | | | | | |
| If Yes, what is the Weekly Compensation | | | | | |
| (Please attach all WorkCover correspondence) | | | | | |
| What payments have been made during the period of disablement | | | | | |
| WorkCover | \$ | From | / | / | To / |
| | | / | | | |
| Normal Pay | \$ | From | / | / | To / |
| | | / | | | |
| What is the usual occupation of the claimant? | | | | | |
| What are his/her primary responsibilities? | | | | | |
| Name of Company | | | | | |
| Contact Details | | Address | | | |
| Suburb | | State | | Postcode | |
| Telephone Number | | Email | | | |
| Signature | | | | | |
| Name | | | | | |
| Position | | | | | |

Thank you for your assistance.

COMPLETING YOUR CLAIM FORM

**We wish to ensure that your claim is processed promptly.
To assist us can you please use this check list?**

- Have you answered ALL questions for your section of the claim form is answered?
- That you have **signed and dated** the claim form.
- The Statement by your usual Doctor is completed.
- The Statement by your treating Doctor is completed, if different from your usual doctor,
OR obtain copies of reports provided to your usual Doctor.
- Employer/Principal Contractor Declaration is attached.

If your disablement is ongoing, a medical certificate must be provided every **TWO WEEKS.**

The certificate must be mailed or faxed to us to make sure benefit payments are not delayed.

**The medical certificate must state the REASON for your disablement.
For example the words "Medical Condition" cannot be accepted.**

If you assist us we will ensure that:-

- You will be notified as soon as your claim has been received.
- Once all the paperwork is received an assessment of your claim will be provided within 5 working days.
- Upon acceptance of your claim Benefit payments are made 2 weeks in arrears thereafter.

PLEASE NOTE: ALL BENEFIT PAYMENTS ARE MADE GROSS, NO INCOME/PAYG TAX IS DEDUCTED FROM THESE PAYMENTS. IT IS YOUR RESPONSIBILITY TO REPORT THIS WHEN DECLARING YOUR ANNUAL TAX RETURN.

PLEASE RETURN YOUR CLAIM FORM (& ongoing Medical Certificates, if applicable) to:

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