Personal Accident & Sickness Claim Form

Important Notices:

- **Instructions**
  - Please refer to the **SRS Personal Accident Product Disclosure Statement and Policy** for details of coverage and general conditions applicable to claims.
  - Please ensure that this Claim Form is completed for all Sections of the Policy which apply to your claim. Any question left unanswered or answered in an incomplete way may delay the processing of your claim.
  - If there is insufficient space provided to fully answer any question, please attach an additional sheet of paper with the extra information as required.
  - Please attach all supporting documentation.
  - All attachments form part of this Claim Form and are subject to the Declaration.
  - The acceptance of this Claim Form does not constitute an admission of liability by Us or a waiver of Our rights.
- **About SRS**

  The SRS Personal Accident Insurance Product Disclosure Statement and Policy are issued by SRS Underwriting Agency Pty Ltd ABN 89 113 929 516 AFSL 290518 as Coverholder and agent on behalf of certain Underwriters at Lloyd's of London. For details of your nearest SRS office, please visit www.srs.com.au or email info@srs.com.au
- **Complaints Handling**

  If You are dissatisfied with the Policy, a decision SRS makes, SRS service, the service of others SRS appoints, or a claim settlement, SRS has an internal dispute resolution process to assist you. For further information, ask for a copy of the SRS Complaints and Disputes Resolution Policy or visit www.srs.com.au.
- **Privacy Statement**

  SRS handles your personal information with care in accordance with the Privacy Act. SRS collects information about you to provide you with insurance products and a claims service. SRS only provides your personal information to certain Underwriters at Lloyd's of London and insurers (who may be located overseas), assessors, claims administrators, claims adjusters, legal advisers, and others appointed by SRS or Underwriters or insurers to assist in providing relevant products and services, or as required or permitted by law. You may elect not to supply SRS with personal information, however, SRS may then not be able to provide you with insurance products and a claims service. Where you provide SRS with personal information about others, SRS relies upon you to have made them aware of that disclosure and of the SRS Privacy Policy and to obtain their consent. You can ask SRS to update this information at any time and access it unless a legal exception applies. For further information about how SRS treats your personal information, ask for a copy of the SRS Privacy Policy or visit www.srs.com.au.
- **General Insurance Code of Practice**

  SRS and Lloyd's of London proudly support the General Insurance Code of Practice. The purpose of the Code is to raise standards of practice and service in the general insurance industry. A copy of the Code can be obtained from www.codeofpractice.com.au, or from SRS upon request.

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1. Personal Statement

(i) Name of Claimant: ....

(ii) Address of Claimant: ....

(iii) Telephone: Day: .... Night: .... Mobile: ....

(iv) Email Address: ....

(v) Date of Birth: .... Height .... Weight ....

(vi) Occupation: ....

(vii) Employer's Name: ....

(viii) Employer's Address: ....

(ix) Telephone Number: .... Fax Number: ....

(x) Location/Department: ....

2. Following Claim acceptance by SRS, please advise preferred method of payment

(i) Employer / Insured - Please confirm:

(a) Please make payment payable to: ☐ Employer/Insured ☐ Claimant

(b) Payment Options: ☐ Cheque ☐ Direct Payment

(c) If you Selected Cheque, nominate payee: ....

(d) If you have selected Direct Payment please supply the following information (alternatively supply a deposit slip noting the following information)

Bank: ....

BSB: .... Account Number: ....

Account Name: ....

3. Statement of Claim (to be completed by Claimant)

(i) When did the accident occur or when did you first become aware of your sickness?

Date: .... Time..am/pm

(ii) What is the date of the first day you were unable to work? ....

(iii) In your own words, please provide a FULL description of how the injury occurred or how you became aware of the sickness:

....

....

....

....

(iv) If injury, please describe exactly what you were doing at the time of your injury (ie. How did the injury happen) and where the injury occurred:

....

....

....

....

(v) Please state when you first became aware of the symptoms before consulting your GP or Specialist:

....

(vi) Which medical practitioner(s) did you consult?

Name: .... Date of Visit ....

Name: .... Date of Visit ....

(vii) What is the name and address of your usual doctor / Family GP?

....

....

Telephone Number: ....

How many years being treated: ....

If less than 5 years please provide details of all doctors seen in the past 5 years:

Name: .... Telephone Number: ....

Name: .... Telephone Number: ....

(viii) Have you ever suffered from this or a similar condition in the past? ☐ Yes or ☐ No

If yes, please provide details and dates:

....

....

....

(ix) During the 24 hours before the injury, did you consume alcohol or drugs? ☐ Yes or ☐ No

If yes, please state types, quantities, and amount of time between last consumption and injury occurred:

....

....

....

(x) Were Police in attendance as a result of this accident? ☐ Yes or ☐ No

If yes, please provide a copy of their report or the attending officer's name and Police Station:

....

....

(xi) Please provide names and addresses of any witnesses:

....

....

(xii) Was hospitalisation required? ☐ Yes or ☐ No

If yes name of hospital: .... Date confined: ....

(xiii) Was the use of an ambulance required? ☐ Yes or ☐ No

(xiv) Are you making, or are you entitled to make a claim in respect of this injury or sickness for any of the following?

(a) Sick Leave ☐ Yes or ☐ No

(b) Centrelink or Other Government Benefits ☐ Yes or ☐ No

(c) Third Party Insurance (Motor Vehicle Accident) ☐ Yes or ☐ No

(d) Worker's Compensation (Work Related Injury/ Sickness) ☐ Yes or ☐ No

(e) Other Insurance (Journey / Travel / Private Health Insurance etc.) ☐ Yes or ☐ No

(f) Superannuation Policy (Income Protection Cover) ☐ Yes or ☐ No

If yes, please provide details including Policy and Claim Number (and dates where applicable):

....

....

(xv) Have you ever made a previous claim in respect to Accident or Sickness Insurance? ☐ Yes or ☐ No

If yes, please provide details including Insurer and Claim Number:

....

....

....

(xvi) Have you engaged in any other income earning employment since you became disabled? ☐ Yes or ☐ No

If yes, please provide details (Name of Employer and attach copies of Pay Slips):

....

....

4. Income Details

If you are self employed complete section (i) only.

If employed as a wage earner, section (ii) is to be completed by your Employer

(i) **IF SELF EMPLOYED:**

If the Claimant is not an Employee (i.e. a self employed contractor) then the gross weekly income derived from personal exertion in their usual occupation, after deducting any expenses necessarily incurred in deriving that income, averaged over the number of weeks so engaged during the twelve (12) months immediately preceding the date disablement giving rise to claim, must be supplied.

(a) Your Accountant's Name: ....

(b) Address: ....

(c) Phone Number: ....

(d) Please confirm employment/position status (ie Director/Partner/Sole Trader): ....

(ii) **IF EMPLOYED AS A WAGE EARNER – TO BE COMPLETED BY YOUR EMPLOYER:**

If employed as a wage earner – to be completed by your Employer

I hereby certify that .... has been unable to attend their usual occupation with the Employer as a result of an injury/injuries or sickness suffered on ....

(a) What was the Claimant's last day of work? ....

(b) When is the Claimant expected to / did resume duties? ....

(c) What is the gross weekly rate of pay inclusive of bonuses, commission, overtime payments and any allowances averaged over the period of 12 months immediately preceding the date of disablement giving rise to this claim?

....

(d) When did the Claimant commence employment with the Employer? ....

(e) Please describe the Claimant's usual occupation: ....

(f) Has the Claimant lodged or intend lodging a Worker's Compensation Claim? ☐ Yes or ☐ No

If yes, please provide copy confirmation of acceptance or rejection (letter) from the Insurer.

Claim Number: .... Workcover Insurer: ....

Telephone Number: ....

(g) Is there any additional information you would like to provide in relation to the submission of this claim?

....

....

....

(h) Name of Supervisor or Paymaster: ....

(i) Telephone Number: .... Fax Number: ....

(j) Email: ....

(k) Signature of Supervisor or Paymaster: ....

(l) Date: ....

5. Doctors Statement (Please Print Legibly – This form cannot be accepted otherwise)

IMPORTANT

(i) The Claimant is responsible for any fee for this statement.

(ii) This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist).

(iii) Dashes or blank spaces are not acceptable – Claim cannot be considered if all information is not provided

Claimant's (Patient's) Full Name: ....

Date of Birth: ....

(iv)

(a) What date were you first consulted by the Claimant in connection with the present condition? ....

(b) If the Claimant was treated by another Doctor or Hospital prior to consulting you please advise name and contact details and dates of consultations:

Doctors Name: ....

Phone Number: ....

(c) How long has the Claimant been experiencing symptoms prior to consulting you for the first time? ....

(d) When do you believe this condition first manifested? ....

(v)

(a) What is the diagnosis and proximate cause of the present sickness or injury?

....

....

....

(b) If X-Ray examination or other tests have been made, state findings and/or attach a copy of reports:

....

....

....

(vi)

(a) Is the current condition in any way related to their work? ☐ Yes or ☐ No

(b) Would you support a Worker's Compensation claim? ☐ Yes or ☐ No

Please explain why or why not:

....

....

....

(vii) Has the Claimant previously suffered from the same or a similar condition? ☐ Yes or ☐ No

(a) Date of Consultation: ....

(b) What was the diagnosis/prognosis of previous conditions?

....

....

....

(c) Was this occurrence/recurrence expected? ☐ Yes or ☐ No

If yes, please explain why:

....

....

....

(viii) Is there anything in the Claimant's medical history that may have contributed or aggravated, either directly or indirectly to the injury/sickness? ☐ Yes or ☐ No

If yes, please provide details:

....

....

....

(ix) Is there anything in the Claimant's medical history that may be likely to delay the recovery? ☐ Yes or ☐ No

If yes, please provide details and advise how long recovery may be delayed:

....

....

....

(x) Please provide summary details of all past and present medical advice and treatment provided to the Claimant in respect of his / her current disablement:

....

....

....

(xi) Have you referred the Claimant to other specialist services or treatment? ☐ Yes or ☐ No

If yes, please provide details and a telephone contact number:

....

....

....

(xii) Has the Claimant continued to follow medical advice? ☐ Yes or ☐ No

If no, please provide details

....

....

....

(xiii) If the Claimant has already been hospitalised, please give name of hospital and dates:

Hospital Name: ....

Date: ....

(xiv) Is there any reason or evidence to suggest the Claimant was under the influence of intoxicants at the time of the accident? ☐ Yes or ☐ No

(xv) If "yes", do you believe the influence of the intoxicants has contributed to or caused the accident to occur? ☐ Yes or ☐ No

(xvi)

(a) When was the Claimant obliged to cease work? ....

(b) When did or when do you realistically expect the Claimant to resume work?

(i) Full unrestricted duties: ....

(ii) Modified duties, if necessary: ....

(iii) Normal duties in reduced capacity (i.e. restricted hours):..

If unable, to return to work in a partial capacity, please provide an explanation:

....

....

....

DOCTOR'S CERTIFICATE

I HEREBY CERTIFY THAT:

- I am a currently registered medical practitioner
- I have personally examined the Claimant
- The particular's recorded in this Doctor's Statement and Certificate are true to the best of my knowledge and belief
- 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
- The Claimant has been and/or will be:
  - totally disabled ☐
  - partially disabled ☐

  from carrying out his / her usual occupation or duties as follows:

  From: .... To: .... (inclusive)
- Additional remarks: (e.g. Prognoses, life expectancy, occupational rehabilitation, surgery waiting list)

  ....

  ....

  ....
- I have read and accept the Privacy Statement provided with this Claim Form

Signature: .... Date: ....

Qualifications: ....

Name: ....

Address:..

Telephone Number: .... Fax Number: ....

Declaration of Insured

I/We declare that:

- I/We have read and understood the **Important Notices** on this Claim Form.
- The answers and information given in this Claim Form are true and correct in all respects.
- I/We agree to SRS collecting, using and disclosing my/our personal information, including sensitive information if applicable, in accordance with the SRS Privacy Policy.

Signature of Insured: .... Date: ....

Full Name: ....

Title: ....

Declaration of Claimant

I declare that:

- I have read and understood the **Important Notices** on this Claim Form.
- The answers and information given in this Claim Form are true and correct in all respects.
- I/We agree to SRS collecting, using and disclosing my/our personal information, including sensitive information if applicable, in accordance with the SRS Privacy Policy.

Signature of Claimant: .... Date: ....

Full Name: ....

Authority for Medical Report

I (please print FULL NAME of Claimant)...
of (address) ....

authorise any medical practitioner, hospital or other person who has attended or examined me in relation to the *injury/sickness which is relevant to this claim to provide to SRS Underwriting Agency Pty Ltd or their authorised representatives, all information in any way relating to the *injury/sickness.

I agree that a copy of this completed authority shall be considered as effective and as valid as the original.

Signature of Claimant: .... Date: ....