Individual Personal Accident & Sickness

Claim Form

ShieldCover®

ShieldCover is a division of East West Insurance Brokers Pty Ltd. ABN 83 010 630 092 AFSL No. 230041

shieldcover.com.au

IMPORTANT INFORMATION

We act upon your claim as soon as we receive this form. You can help us in the assessment of your claim, if you:

1. Complete this form in full. Supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents as indicated may result in a delay in processing your claim.
2. Provide a comprehensive description of the circumstances of the accident/injury or the sickness.
3. If this claim form does not provide enough space, please use a separate piece of paper and attach as supplementary information.
4. When all information has been completed, please forward the claim form to ShieldCover.

PERSONAL DETAILS		
Claimant Name		
Postal Address		
		Postcode
Telephone No.		**Mobile No.**
Email Address		**Facsimile No.**
Date of Birth	**Height**	**Weight**
Occupation/Duties		
Employer's Name		**Telephone No.**
Location/Department		

FOLLOWING CLAIM ACCEPTANCE BY YOUR INSURER, PLEASE ADVISE PREFERRED METHOD OF PAYMENT

☐ **Direct Payment*** ☐ **Cheque****

*If Direct Payment selected, please supply the following information (alternatively, supply a deposit slip noting the following information).
**If cheque selected, please nominate Payee name.

Bank	**Account Name**
BSB Number	**Account Number**

STATEMENT OF CLAIM (to be completed by the claimant)	
1. When did the accident occur or when did you first become aware of your sickness?	
Date	**Time** ☐ **AM** ☐ **PM**
2. What is or was the date of the first day you were unable to work?	
3. In your own words, please provide a FULL description of how the injury occurred or how you became aware of the sickness.	
4. If injury, please describe exactly what you were doing at the time of your injury (ie.how did injury happen) and where the injury occurred i.e. street name, suburb, etc.	
5. Please state when you first became aware of symptoms before consulting your GP or Specialist.	
6. What medical practitioner(s) did you consult?	
Name	**Date of Visit**
Address	**Telephone No.**
Name	**Date of Visit**
Address	**Telephone No.**
Name	**Date of Visit**
Address	**Telephone No.**
7. What is the name, address and phone no. of your usual doctor? (Family General Practitioner)	
Name	**Date of Visit**
Address	**Telephone No.**
Number of years treated by this Doctor	

8. Have you ever suered from this or a similar condition in the past? If yes, please provide details and dates.	
Date	**Details**
Date	**Details**
9. During the 24 hours before the injury, did you consume alcohol or drugs? If yes, please state types, quantities and amount of time between last consumption and injury occurring.	
10. Were Police in attendance as a result of this accident? If yes, please provide a copy of their report or the attending officer's name and Police Station.	
Attending Officer's Name	**Police Station**
11. Please provide names and addresses of any witnesses.	
Name	**Contact No.**
Address	
Name	**Contact No.**
Address	
12. Was hospitalisation required? If yes, you must obtain and provide a copy of the ED/Triage report)	
Name of Hospital	**Confined Dates From**
	To
13. Was the use of an ambulance required?	☐ **Yes** ☐ **No**

14. Are you making, or are you entitled to make a claim in respect of this injury or sickness for any of the following?	
Sick Leave	☐ Yes ☐ No
Third Party Insurance (Motor Vehicle Accident)	☐ Yes ☐ No
Other Insurance (Journey/Travel/Private Health Insurance)	☐ Yes ☐ No
Centrelink or other Government Benefits	☐ Yes ☐ No
Worker's Compensation (Work Related Injury/ Sickness)	☐ Yes ☐ No
Superannuation Policy (Income Protection Cover)	☐ Yes ☐ No
If yes, please provide details including Policy or Claim Number (and dates where applicable)	
15. Have you ever made a previous claim in respect to Accident or Sickness insurance? If yes, please provide details including Insurer and Claim Number. ☐ Yes ☐ No	
Insurer	Claim Number
Insurer	Claim Number
16. Have you engaged in any other income earning employment since you became disabled? If yes, please provide details (Name of Employer and pay slips).	
Employer	Contact No.
Employer	Contact No.
Employer	Contact No.
Employer	Contact No.

CLAIMANT AUTHORITY AND CONSENT DECLARATION

I declare I am the person named on this form or I have a power of attorney to act on the Claimant's behalf. I declare that the information provided in this form, to the best of my knowledge and beliefs are true and correct and if any answers to the questions completed in this form are not in my handwriting. I have certified that I have checked them and they are also correct.

I understand that if I have made or make any false, misleading of fraudulent statements, conceal or intentionally withhold relevant information for the assessment or ongoing review of this claim, ShieldCover may:

- Refuse to pay this claim;
- Recover benefits paid that were based on false or misleading information I provided;
- Be obliged to refer such case to relevant Authority.

I declare and authorise that I have read and understood the Privacy Information provided with this form and I understand that my personal and sensitive information, may be disclosed to other parties as advised below and approve these purposes.

I hereby authorise and direct any medical attendent, Doctor, Hospital or other medical or health service to divulge to ShieldCover, its representatives or any legal tribunal, and to release at any time details of my personal medical history, including referrals to or treatment by any other Practitioners, any health or other information acquired with regard to myself for the purposes of allowing ShieldCover to assess my claim or assess any new, additional insurances (including re-instatements).

I also authorise my current and any previous Employer to release to ShieldCover any personal pr health information requested to facilitate an assessment of my claim. Under Government Privacy Legislation, I may access a copy of any reports provided to ShieldCover.

I authorise ShieldCover to obtain from Medicare such portion of my claims history deemed necessary by ShieldCover to properly assess my claim.

I also authorise the institutions listed below to provide ShieldCover any health and other personal information that ShieldCover considers essential and/or reasonable to further assess or evaluate my claim. I further authorise ShieldCover to contact, release and obtain information it requires to assess my claim for benefits, from those other sources it consider necessary including, but not limited to the following:

- Any Doctor, ambulance, hospital or other health service provider.
- My employer, previous employer's accountant/s and/or Financial Advisors and/or Union Delegate or Representative.
- Medicare, the Insurance Commission including PBS RECORDS.
- Any Insurance Company, including Workers Compensation Insurer.
- Insurance or financial reference agencies, re-insurers, financial institutions including banks, credit unions, building societies, mortgage providers, finance companies, (and Claims investigators, Private Investigators and Detectives and Forensic Accountants.
- Government Agencies, including, but not limited to Centrelink, Australian Taxation Office, Australian Securities and Investments Commission, Department of Veterans' Affairs and Department of Immigration and Multicultural and Indigenous Affairs.
- Any Federal, State or Territory Police Department.
- Traffic Accident Commission (Victoria), State and Territory Roads and Traffic Authorities, Queensland Transport, Vic Roads Registration and Licensing Office, Transport South Australia.
- Any other Institutions that hold my personal information.

I understand that ShieldCover may be required to submit all documentation to a mediator, Solicitor, Complaints Resolution Tribunal or Court or to any other person necessary for claims determination purposes including the

Trustee of any Superannuation Plan.

I understand a determination of my claim may no t be possible if I withhold consent and authority for ShieldCover to seek personal and/ or health information in relation to my claim.

I agree that a scanned, photocopied or faxed copy of this authority shall be considered as effective and valid as the original.

Signature of Claimant

Name of Claimant (please print)

Date

INCOME DETAILS (Delete 1 or 2, whichever is not applicable)
1. IF SELF EMPLOYED If the claimant is not an employee (i.e. a self employed contractor), then the gross weekly income derived from the personal exertion of the Insured Person is 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 of disablement giving rise to claim, must be supplied.
Your Accountant's Name
Address
Telephone no.
Please confirm employment/position status (i.e. Director/Partner/Sole Trader).
2. 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:** **company as a result of an injury/injuries/sickness suffered on:**
a. What was the employees last day at work?
b. When is the employee expected to/did resume duties?
c. If the claimant is an Employee, please complete the attached Declaration of Pre-Disability Earnings Form to confirm earnings across the number of weeks so engaged during the fifty two (52) weeks immediately preceding the date of disablement giving rise to this claim.
d. When did the claimant commence employment with the Company?
e. Please describe the claimants usual occupation.
f. Has the employee lodged or intend lodging a Worker's Compensation Claim? **If yes, please provide copy confirmation of acceptance or rejection (letter) from the insurer.** ☐ **Yes** ☐ **No**

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

☐ Yes ☐ No

EMPLOYER/COMPANY DETAILS

Name of Company	
Postal Address	
	Postcode
Signature of Supervisor or Paymaster	
Name of Supervisor or Paymaster	
Telephone No.	**Fax No.**
Email Address	

DECLARATION OF PRE-DISABILITY EARNINGS

Employer – please note. It is your responsibility to complete this form and calculate the average weekly earnings in line with the policy definition of "earnings" as described below

WEEKLY EARNINGS DURING THE 52 WEEKS PRIOR TO INCAPACITY – for Employees

Employees Name:

PLEASE READ THE FOLLOWING DEFINITION OF "EARNINGS" FOR EMPLOYEES BEFORE COMPLETING THIS FORM:

"If an employee, the gross weekly rate of pay inclusive of bonuses, commission, overtime payments and all other allowances, from the personal exertion of the Insured Person in their usual occupation, averaged over the number of weeks so engaged during the twelve (12) month period immediately preceding the date Disablement commences."

Gross Annual Income – $	
Average Gross Weekly Rate of Pay – $	

To avoid delays, please ensure that this form is fully completed with ALL "Earnings" as detailed in the definition above. **Please note the Weekly Benefit entitlements will be calculated upon the information/declaration that your provide.** **I sincerely DECLARE that to the best of my knowledge the information provided above is true, accurate and complete.**

Payroll Officer's Name	**Date**
Payroll Officer's Signature	

DOCTORS STATEMENT (Please print legibly – this form cannot be accepted otherwise)

IMPORTANT

1. The patient is responsible for any fee for this statement
2. This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist or any other Allied Health Professional)
3. Dashes or blank spaces are not acceptable – claim cannot be considered if all information is not provided

Patient's Full Name
Patient's Date of Birth

1. a) What date were you first consulted by the Patient in connection with the present condition?	
b) How long had the patient been experiencing symptoms prior to consulting you for the first time?	
c) When do you believe this condition manifested?	
d) How long has this patient been under your care? (Please state months and/or years).	
2. 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 finding and/or attach copy of reports.						
3. a) Is the current condition in any way related to their work?				☐ **Yes**	☐ **No**	
b) Would you support a Worker's Compensation Claim?				☐ **Yes**	☐ **No**	
Please explain why/why not?						
4. Has the patient previously similar condition?				☐ **Yes**	☐ **No**	
a) Date of consultations						
b) What was the diagnosis/prognosis of previous condition?						
c) Was this occurrence/recurrence expected? If yes, please explain why. ☐ **Yes** ☐ **No**						
5. Is there anything in the patient's medical his tory that may have contributed or aggravated, either directly or indirectly to the injury/sickness? If yes, please provide details below. ☐ **Yes** ☐ **No**						
6. Is there anything in the patient's medical history that may be likely to delay the recovery? If yes, please provide details below and advise how long recovery may be delayed. ☐ **Yes** ☐ **No**						

7. Please provide summary details of all pas t and present medical advice and treatment provided to the patient in respect of his /her current disablement.		
8. Have you referred the patient to other specialist services or treatment? If yes, please provide details and a telephone contact number. ☐ Yes ☐ No		
Details		**Telephone No.**
Details		**Telephone No.**
Details		**Telephone No.**
9. Has the patient continued to follow medical advice? If no, please provide details. ☐ Yes ☐ No		
10. If the patient has already been hospitalised, please give name of hospital and dates.		
Name	**Dates from**	**To**
Name	**Dates from**	**To**
Name	**Dates from**	**To**
11. Is there any reason or evidence to suggest the Patient was under the influence of intoxicants at the time of the accident?		☐ Yes ☐ No
12. If yes, do you believe the influence of the intoxicants has significantly contributed to or caused the injury or sickness onset to occur?		☐ Yes ☐ No
13. a) When was the patient obliged to cease work?		
b) When did or when to you realistically expect the Patient to resume work?		
i) Full unrestricted duties?		
ii) Modified duties, if necessary?		
iii) Normal duties in reduced capacity (ie. restricted hours).		
If unable to return to work in a partial capacity, please provide an explanation.		

14. I hereby certify that the patient has been and/or will be totally disabled from carrying out his/her duties as follows:	
Dates From	**To** **(inclusive)**
Additional remarks: (e.g. Prognoses, life expectancy, occupational rehabilitation, surgery waiting list)	

Doctor's Name	
Doctor's Address	
Telephone No.	**Fax No.**
I hereby certify that I have personally examined the above-named patient and that in my opinion the statements made in the Statement of Claim section of this Claim Form are consistent with the patient's injury or sickness.	
I have read and accept the Privacy statement provided with this Claim Form.	**Date**
Signature	**Qualifications**

PRIVACY STATEMENT

ShieldCover, a division of East West Insurance Brokers Pty Ltd, is committed to protecting your privacy in accordance with the Privacy Act 1998 (Cth) and the Australian Privacy Principles. This Privacy Policy describes our current policies and practices in relation to the collection, handling, use and disclosure of personal information. It also deals with how you can complain about a breach of the privacy laws and how you can access the personal information we hold and how to have that information corrected.

What information do we collect and how do we use it?

When we arrange insurance on your behalf, we ask you for the information we need to advise you about your insurance needs and management of your risks. This can include a broad range of information ranging from your name, address, contact details and age to other information about your personal affairs including your assets, personal belongings, financial situation, health and wellbeing. We provide any information that the insurers or intermediaries who we ask to quote for your insurances and premium funding require to enable them to decide whether to insure you and on what terms, or to fund your premium and on what terms.

Insurers may in turn pass on this information to their reinsurers. Some of these companies are located outside Australia. For example, if we seek insurance terms from an overseas insurer (e.g. Certain Underwriters at Lloyd's), your personal information may be disclosed to the insurer. If this is likely to happen, we inform you of where the insurer is located, if it is possible to do so.

When you make a claim under your policy, we assist you by collecting information about your claim. Sometimes we also need to collect information about you from others. We provide this information to your insurer (or anyone your insurer has appointed to assist it to consider your claim, e.g. loss adjusters, medical brokers etc) to enable it to consider your claim. This information may be passed on to reinsurers.

From time to time, we may use your contact details to send you direct marketing communications including offers, updates and newsletters that are relevant to the services we provide. We will always give you the option of electing not to receive these communications in the future. You can unsubscribe by notifying us and we will no longer send this information to you.

What if you don't provide some information to us?

We can only fully advise you and assist in arranging your insurance or with a claim, if we have all relevant information. The insurance laws also require you to provide your insurers with the information they need in order to be able to decide whether to insure you and on what terms. You have a duty to disclose the information which relevant to the insurer's decision to insure you.

When do we disclose your information overseas?

If you ask us to seek insurance terms and we recommend an overseas insurer, we may be required to disclose the information to the insurer located outside Australia. For example, if we recommend a policy provided by Lloyd's, your information may be given to the Lloyd's broker and certain underwriters at Lloyd's to make a decision about whether to insure you.

We will tell you at the time of advising on your insurance if the insurer is overseas and in which country the insurer is located. If the insurer is not regulated by laws which protect your information in a way that is similar to the Privacy Act, we will seek your consent before disclosing your information to that insurer.

Australian and overseas insurers acquire reinsurance from reinsurance companies that are located throughout the world, so in some

cases your information may be disclosed to them for assessment of risks and in order to provide reinsurance to your insurer. We do not make this disclosure; this is made by the insurer (if necessary) for the placement for their reinsurance program.

We may also disclose information we collect to the providers of our policy administration and broking systems that help us to provide our products and services to you. These policy administration providers and broking systems may be supported and maintained by organisations in New Zealand, the Philippines and Vietnam and your information may be disclosed to those organisations. We currently offshore employees in Kuala Lumpur and may also offshore employees in other countries.

Please note that the Privacy Act and Australian Privacy Principles may not apply to these organisations.

How do we hold and protect your information?

We strive to maintain the reliability, accuracy, completeness and currency of the personal information we hold and to protect its privacy and security. We keep personal information only for as long as is reasonably necessary for the purpose for which it was collected or to comply with any applicable legal or ethical reporting or document retention requirements.

We hold the information we collect from you initially in a working file, which when completed is electronically imaged and stored, after which any paper is destroyed in our onsite shredder.

We ensure that your information is safe by protecting it from unauthorised access, modification and disclosure. We maintain physical security over our paper and electronic data and premises, by using locks and security systems. We also maintain computer and network security; for example, we use firewalls (security measures for the Internet) and other security systems such as user identifiers and passwords to control access to computer systems where your information is stored.

Will we disclose the information we collect to anyone?

We do not sell, trade, or rent your personal information to others.

We may need to provide your information to contractors who supply services to us, e.g. to handle mailings on our behalf, external data storage providers or to other companies in the event of a corporate sale, merger, re-organisation, dissolution or similar event. We may also disclose information we collect to the providers of our policy administration and broking systems that help us to provide our products and services to you. However, we will take reasonable measures to ensure that they protect your information as required under the Privacy Act.

We may provide your information to others if we are required to do so by law, you consent to the disclosure or under some unusual other circumstances which the Privacy Act permits.

How can you check, update or change the information we are holding?

Upon receipt of your written request and enough information to allow us to identify the information, we will disclose to you the personal information we hold about you. We will also correct, amend or delete any personal information that we agree is inaccurate, irrelevant, out of date or incomplete.

If you wish to access or correct your personal information, please write to our Privacy Officer at ShieldCover, PO Box 239, Coopers Plains, Queensland 4108.

We do not charge for receiving a request for access to personal information or for complying with a correction request. Where the information requested is not a straightforward issue and will involve a considerable amount of time and then a charge will need to be confirmed for responding to the request for the information.

In some limited cases, we may need to refuse

access to your information, or refuse a request for correction. We will advise you as soon as possible after your request if this is the case and the reasons for our refusal.

What happens if you want to complain?

If you have concerns about whether we have complied with the Privacy Act or this privacy Policy when collecting or handling your personal information, please write to our Privacy Officer at ShieldCover PO Box 239, Coopers Plains, Queensland 4108.

Your complaint will be considered by us through our internal complaints resolution process and we will try to respond with a decision within 45 days of you making the complaint.

Your consent

By asking us to assist with your insurance needs, you consent to the collection and use of the information you have provided to us for the purposes described above.

Website information and content

The information provided on this website does not cover all aspects of the law on the relevant subject matter. Professional advice should be sought before any action is taken based upon the matters described and discussed on this site.

To the extent permitted by law, we make no representations about the suitability of the content of this site for any purpose. All content is provided without any warranty of any kind. We disclaim all warranties and conditions with regard to the content, including but not limited to all implied warranties and conditions of fitness for a particular purpose, title and non-infringement.

We will not be liable for any damages or injury caused by, including but not limited to, any failure of performance, error, omission, interruption, defect, delay in operation of transmission, computer virus, or line failure. To the extent permitted by law we will not be liable for any damages or injury, including but not limited to, special or consequential damages that result from the use of, or the inability to use, the materials in this site.

We believe the content of this site to be accurate, complete and current; however, there are no warranties as to the accuracy, completeness or currency of the content. It is your responsibility to verify any information before relying on it. The content of this site may include technical inaccuracies or typographical errors.

We reserve the right to modify the content of this site from time to time.

Tell us what you think

We welcome your questions and comments about privacy. If you have any concerns or complaints, please write to our Privacy Officer at ShieldCover, PO Box 239, Coopers Plains, Queensland 4108 or by telephone number (07) 3510 9535 or email privacy@shieldcover.com.au

LLOYD'S

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ShieldCover

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