Claim form

Personal Accident

ZURICH

All relevant sections are to be answered in full. Please print your answers.
The company does not admit liability by the issue of this form.
It is issued to enable the insured to lodge a written statement of claim.

Claim No. (Office use only)	
Type of insurance cover	

Branch
Policy No.
Due date
Broker/Agent
Address

Important information

In the event of a Claim, Zurich Australian Insurance Ltd will:

- Within 10 business days of receipt of your claim we will notify your broker (or you) of our decision as to whether the claim has been accepted or not or, advise you if we require additional information and/or if we have appointed a loss assessor/Investigator.
- For claims where additional information is required we will make a decision within 20 business days, dependant upon the time required for you (or other independent parties) to respond to a request for additional information. If we are reasonably satisfied that all the relevant information pertaining to the claim has been made available, we will then decide to accept or deny the claim and notify you of our decision within the above timeframe.
- In some cases, due to unusual circumstances or the complexity of a claim (such as liability claims), these timeframes may not be practical and we will agree an alternate timeframe with your broker or you to make a decision on your claim. If we cannot reach an agreement, you are able to access our complaints handling procedures.
- Please be aware that in accordance with the General Insurance Code of Practice, these standards will not apply if any person who may be entitled to benefits under the policy has commenced proceedings in any court, tribunal or any other dispute handling process (other than the Insurance Ombudsman Service) in respect of this claim.

Privacy

- We need personal information about you to assess your claim. We will, where relevant, disclose your personal information (other than sensitive information such as health information) to your adviser (and any licensee or broker he or she represents), to our service providers (including loss adjusters and investigators), other insurers, insurance reference bureaus and our business partners for this purpose;
- Where relevant, to assess your claim we will also disclose personal information, including sensitive information about you such as health information, to medical practitioners, other health professionals, other insurers and reinsurers, legal representatives, and other consultants. By signing this Claim Form, you consent to those organisations and other professionals collecting, and us disclosing sensitive information about you for this purpose;
- In some cases, assessment and settlement of the claim is undertaken in conjunction with our insured. For example, we may act as an agent for our insured or the cost of claims may be shared between us and our Insured. In these cases, your personal and/or sensitive information will be shared between us and our insured (or their representatives) for the purpose of managing the claim;
- A list of the type of service providers, business partners and consultants we commonly use is available on request, or on our website - go to www.zurich.com.au and click on the Privacy link on our home page;
- If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of your claim may be delayed or we may not accept the claim;
- We may also disclose personal information about you where we are required or permitted to do so by law;
- In most cases, on request, we will give you access to the personal information we hold about you;
- If you would like to find out more, you can contact us by telephone on 132 687, e-mail us at Privacy.Officer@zurich.com.au or write to 'The Privacy Officer' at Zurich Financial Services Australia Limited, PO Box 677, North Sydney, 2059. Please provide details of your policy number/s and/or claim number where known.

Insured

Full name of Insured – Mr, Mrs, Miss, Ms

Occupation

Address State Postcode

What is your ABN ☐☐ ☐☐☐ ☐☐☐ ☐☐☐ What is your ITC% for this risk %

Phone number (Private) (Business)

Policy No. Age Weight Height

Are you self employed? Yes ☐ No ☐ If 'No', please provide name and address of your employer

Name

Address State Postcode

Please indicate which of the following best describes your present occupation:-

(a) Clerical Work only ☐ (b) Performing Manual Work ☐ (c) Supervising Manual Work ☐ (d) Combination of (b) & (c) ☐

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Accident details

Date of accident / / Time of accident am/pm Date present incapacity commenced / /

Describe exactly how the accident occurred

Nature and extent of injuries

Have you ever sustained an injury of this type in the past? Yes ☐ No ☐ If 'Yes', please provide details

Where did accident occur?

Did this accident occur at work, or on a journey to/from work? Yes ☐ No ☐ If 'Yes', are you entitled to Workers' Compensation?

Did you consume any drug or intoxicating liquor during twelve hours prior to the accident? Yes ☐ No ☐
If 'Yes', please provide specific details

General particulars

Can compensation be claimed from any other company or insurer? Yes ☐ No ☐
If 'Yes', please provide Name and Address of such organisation

Name

Address State Postcode

Have you been able, since the accident happened, to attend in **ANY WAY** to your business or employment? Yes ☐ No ☐
If 'Yes', please provide details

What are your average weekly earnings $ When did you first obtain medical attention? / /

Please provide Name and Address of Medical Attendant

Name

Address State Postcode

DECLARATION ON PAGE 4 TO BE SIGNED

Medical Statement

Personal Accident

ZURICH

To be furnished by the person claiming at his own expense

To be forwarded to the company within seven days. After receipt by the insured, fully completed by a duly registered medical practitioner.

Name of Claimant (Patient)

Address State Postcode

Occupation

Date accident happened or commenced and where / /

How caused

On what date did you first attend the Claimant in consequence of present injured? / /

(If the injuries sustained to a hand or an arm, a foot or a leg, state whether it is the Right or Left).

Have you reason to suspect Claimant was not sober at the time of accident? Yes ☐ No ☐ If 'Yes', please give details

How long have you known the Insured?

Are you the Claimant's regular Medical Attendant? Yes ☐ No ☐ If 'No', who is the regular medical attendant?

To your knowledge, was the Insured at the time of the accident suffering from any disease or physical infirmity? Yes ☐ No ☐
If 'Yes', please provide details

Give date of last visit by the Claimant / /

Is the Claimant's incapacity due solely and directly to the accident stated, independently of any other cause? Yes ☐ No ☐
If 'Yes', please provide details

Note: Temporary Total Disablement by Accident means: that the **Patient is rendered totally unable** to engage in or attend to his usual profession, business or occupation.

Temporary Partial Disablement by Accident Only means: that the **Patient is rendered unable in material degree** to attend to or engage in his usual profession, business or occupation.

I Estimate the Claimant will be **Totally** disabled for:

weeks days

I Estimate the Claimant will be **Partially** disabled for:

weeks days

I HEREBY CERTIFY that the foregoing statements are to the best of my knowledge, information and belief, true and complete, and that I am firmly of the opinion that the stated periods of the patient's Total and/or Partial Disablement are due solely and directly to the cause or causes I have stated.

Name (Please Print)

Address State Postcode

Qualification

Signature Date

✗ / /

Declaration

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sicknesses shall be forfeited.

I further agree that any Professional person, Medical Practitioner or Hospital Authority who has been or may hereafter be consulted by me relative to the injury is hereby authorised and directed by me to divulge at any time to Zurich Australian Insurance Limited, their legal representatives or Loss Adjusters, any information or history they may have acquired with regard to any injury.

Signature of insured ✗ Date / /

Certificate of TOTAL Disablement

To be retained by Insured for Completion on Recovery or returned completed with claim form if recovery complete

This is to certify that I have examined Mr, Mrs, Miss, Ms

..... on / /

In my opinion he/she is/was suffering from

.....

.....

.....

He/she will be/was **totally** unfit for work from / / and up to and including / /

Qualification .....

Signed ✗ Date / /

The exact injury causing the disability/incapacity **must** be stated.

Certificate of PARTIAL Disablement/Incapacity

This is to certify that I have examined Mr, Mrs, Miss, Ms

..... on / /

In my opinion he/she is/was suffering from

.....

.....

.....

He/she will be/was **partially** unfit for work from / / and up to and including / /

Qualification .....

Signed ✗ Date / /

The exact injury causing the disability/incapacity **must** be stated.