ace insurance

**ACE Insurance Limited**
**ABN 23 001 642 020**
28-34 O'Connell Street
Sydney NSW 2000
Australia

GPO Box 4065
Sydney NSW 2001
Australia

1800 688 640 *claims phone*
1800 815 675 *customer service*
+61 (0)2 9231 3697 *claims fax*
a&h.claims.australia@acegroup.com
www.aceinsurance.com.au

# Personal Injury Claim Form

## IMPORTANT INFORMATION

1. Please complete the Policy Details Section and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully.
3. To avoid delay in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
4. Claims may be subject to an excess as described in your Policy.
5. Please send this form and all documentation to: **The Accident & Health Claims Department, ACE Insurance Limited, GPO Box 4065, Sydney, NSW 2001.**

## A. POLICY AND CLAIMANT DETAILS COMPLETE FOR ALL CLAIMS

POLICYHOLDER Claiman ☐ Other ☐ - Given Name | Mr/Mrs/Miss/Ms

Policy / Certificate Number | Expiry Date / /

Name of Broker who provided the cover

| | |
|---|---|
| Name | Surname First Names |
| Home Address | State Postcode |
| Postal Address (if different from above) | State Postcode |
| Telephone Numbers | Private ( ) Business ( ) Mobile |
| Email Address | |
| Employer's Name | |
| Occupation | |
| Usual Duties | Date of Birth / / |

What are your gross weekly earnings: $

Who are you claiming for: Self ☐ Spouse/Partner ☐ Child ☐ – Give Name

What are you claiming for? (e.g. Temporary Total Disablement)

## Electronic Funds Transfer Details

Following ACE approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

Name of Financial Institution: Account Name:

BSB Number: Account Number:

## GST Information (For Australian Claims Only)

(a) Are you registered for GST Purposes? Yes ☐ No ☐

(b) What is your Australian Business Number (ABN)?

(c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? Yes ☐ No ☐

(d) IF **YES**, what percentage of the GST did you claim or are you entitled to claim? %
(if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

## B. CLAIMS FOR INJURY / ILLNESS / DEATH

**What is the injury or illness?**

**If injury, how exactly did it occur?** i.e. playing sport, etc.

**When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed?** / /

**Did the injury or illness cause you to stop work?** No ☐ Yes ☐ –when? / /

**Have you returned to work full-time?** No ☐ Yes ☐ –when? / /

**OR**

**Have you returned to work part-time?** No ☐ Yes ☐ –when? / /

– if Yes, what hours and duties are you working? Days Hours

Duties

**Is this condition due to injury or sickness arising out of your employment?** No ☐ Yes ☐ –give details

If Injury, how exactly did it occur?

**Who is your usual family doctor?**

Name

Address

Telephone Number

**When did you first get treatment from a medical practitioner for this condition?**

Doctor's Name

Address

Telephone Number

When did you first see the medical practitioner? / /

**Have you consulted any other medical practitioner for this condition?** No ☐ Yes ☐ - give details

Doctor's Name

Address

Telephone Number

Period

**Did you go to hospital?** No ☐ Yes ☐ - give details

Hospital Name

Address

Dates of Admission and Discharge Admission / / Discharge / /

Number of Days in Hospital

**During the 24 hours before the injury, did you drink any alcohol or take any drugs?** No ☐ Yes ☐ - give details

State types & quantities

**Have you ever had this or a similar condition in the past?** No ☐ Yes ☐ – give details

| | |
|---|---|
| Date(s), | |
| Treatment received | |
| Name of treating Doctors/Specialists | |
| Addresses of Doctors/Specialist who treated you | |

**What other significant medical or surgical treatment have you received in the past 5 years?** – give details

| | |
|---|---|
| Date(s) | |
| Nature of the condition(s) treated | |
| Name of treating Doctors/Specialists | |
| Addresses of Doctors/Specialist who treated you | |

**Are you affected by any other long term or chronic disability** No ☐ Yes ☐ – give details

## C. CLAIMS FOR ADDITIONAL BENEFITS FOR INJURY OR ILLNESS

**NOT ALL POLICIES PROVIDE THESE BENEFITS. PLEASE ONLY COMPLETE IF APPLICABLE**

Are you claiming for:-

- **homecare or income replacement after major surgery for cancer**
- **childminding or income replacement after a child's accident**
- **home tuition fees after a child's accident**
- **medical expenses not covered by Medicare**
- **damage to personal property**

Give details, specifying each item

| ITEM | AMOUNT |
|---|---|
| | |
| | |
| | |
| | |

***PLEASE ATTACH INVOICES OR OTHER EVIDENCE OF THE EXPENSES YOU HAVE INCURRED OR RECEIPTS FOR DAMAGED PROPERTY.***

## D. OTHER INSURANCE / BENEFITS

**Are you claiming insurance or compensation from any other insurance company?** eg. Workers Compensation, Traffic Accident Commission, sports body or any income replacement.

No ☐ Yes ☐ – give details below

| | |
|---|---|
| **Name of insured organisation/employer & telephone number** | |
| **Name of Insurer & Telephone No.** | |
| **Type of cover** | |
| **Amount claimed per week** | per week |

**Do you have private health insurance?** No ☐ Yes ☐ – give details

**Do you have ambulance cover?** No ☐ Yes ☐ – give details

## E. TO BE COMPLETED BY YOUR EMPLOYER

**If Self Employed please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earnings.**

Name of Employer

This is to certify that of

has been unable to attend his/her occupation as a result of Injury or Sickness from / / to / /

His/Her average Gross Weekly Salary at the time of this accident/sickness was A$ per week

He/She has been employed since / /

His/Her Sick Leave Entitlement at the time of this accident/sickness was days

Has a claim for Worker's Compensation been lodged ☐ Yes ☐ No

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission? ☐ Yes ☐ No

Signature of Employer or Supervisor

Name of Employer or Supervisor (please print)

Telephone Number Date

## ACE Insurance Limited Claim Privacy Consent, Medical Authority and Declaration

### Claim Privacy Consent

ACE Insurance Limited (ACE) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principles.

A copy of our Privacy Policy is available on our website at www.aceinsurance.com.au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by ACE, or any third party that ACE provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:

- Any information provided in relation to your claim;
- Any information that is health information or sensitive information, including without limitation your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
- Any other personal information that you may provide to ACE or its third party contractors;
- Any information relating to any insurance policy on your life, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- Any other information relating to your income, assets, liabilities and solvency; and
- Any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ACE group, other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. ACE may also disclose your personal information to witnesses in respect to your claim.

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, ACE may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1800 815 675 or email customer.relations@acegroup.com.

### Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to ACE using and disclosing my personal information pursuant to ACE's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to ACE's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to ACE such personal information (including health information) as ACE is its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to ACE in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint ACE to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant

Date

/ /

Name of Claimant

Signature of Witness

Date

/ /

Name of Witness

# Medical Practitioner's Statement to Company

**THE POLICYHOLDER IS RESPONSIBLE FOR ANY FEE FOR THIS STATEMENT**
**THIS FORM SHOULD BE COMPLETED AND RETURNED TO ACE PROMPTLY**

**Patient's Full Name** | **Date of Birth** / /

**Height** **cms** **Weight** **kgs**

**Diagnosis** (if fracture or dislocation, describe nature and location i.e.: **Simple, Compound**

Cause:-

If available please provide a copy of X-ray report

Is this condition an injury ☐ or an illness ☐

**Does the patient have any other injury or illness that is contributing to the condition? eg: Osteoporosis** No ☐ Yes ☐ – give details

**Is condition due to injury or sickness arising out of the patient's employment?** No ☐ Yes ☐ – give details

**Was the disability, sports related?** No ☐ Yes ☐ – give details

**Date of onset/first symptoms?**

**When did the patient first consult you for this condition?**

**Has the patient ever had the same or similar condition?** No ☐ Yes ☐ – give details

**How long have you been the patient's usual doctor/medical practice?** ☐ yrs

**Has the patient been hospitalised** Date of Admission | Date of Discharge

Name of Hospital

**Name of patient's usual doctor/medical practice**

**Has the patient had surgery or is it anticipated?** No ☐ Yes ☐ – give details

**Date performed or anticipated** / / **Give name of hospital?**

**Did you provide other medical services (including pathology) to the patient?** No ☐ Yes ☐ – itemise, give details

| | |
|---|---|
| Date / / | |
| Date / / | |

**Was the patient referred by you or to you?** No ☐ Yes ☐ – give details

| | |
|---|---|
| Please provide name and address of referring doctor | Name<br>Address |
| Date of referral | / / |

**Is the patient still disabled?**

No ☐ – when did the patient return to work? / /

Yes ☐ – how long will the patient be:

- totally disabled (unable to perform any part of their occupation)

  from / / to / /

- partially disabled (able to perform part of their occupation)

  from / / to / /

**If partially disabled, what duties could the patient perform and for how many hours a week?**

| |
|---|
| |
| |
| Hours per week |

**Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body?**

No ☐ Yes ☐ – give details

| |
|---|
| Name of Company and Claim No. |
| Contact Name and Telephone No. |

**Remarks**

| |
|---|
| |
| |
| |
| |
| |

| | | |
|---|---|---|
| **Signature of medical practitioner** | | |
| **Name – print** | | Date / / |
| **Qualifications** | | |
| **Address** | | |
| **Telephone Number** | | |

ace insurance

**ACE Insurance Limited**
**ABN 23 001 642 020**
28-34 O'Connell Street
Sydney NSW 2000
Australia

GPO Box 4065
Sydney NSW 2001
Australia

1800 688 640 *claims phone*
1800 815 675 *customer service*
+61 (0)2 9231 3697 *claims fax*
a&h.claims.australia@acegroup.com
www.aceinsurance.com.au

## To Be Completed by the Insured for all Claims on Group Personal Injury and/or Sickness Policies

I, _____

confirm that _____

is an Employee/Member/Volunteer Worker/Other (Please Specify) _____

of (Company Name) _____

and that he/she is eligible to claim for the Injury/Illness occurring on _____/_____/_____

Signature _____

Name _____

Title _____

Contact Number _____

Claim Reference (if known) _____

Policy Number (if known) _____