ASPECT UNDERWRITING

Coverholder at LLOYD'S

PERSONAL ACCIDENT & SICKNESS CLAIM FORM

Important Notices

Instructions

- Please refer to the **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.

Claims Lodgement

Email: newclaimsAH@eml.com.au
Post: EMLplus
GPO Box 4580
Sydney NSW 2001

Privacy

Aspect Underwriting and our Claims Management Provider – EML - handle your personal information with care and in accordance with the Privacy Act 1988 and the Australian Privacy Principles. We collect personal information about you to provide you with insurance and insurance related services. We may disclose your personal information to third parties for the purposes described in our Privacy Policy, including related entities, insurers, reinsurers, agents and service providers, some of whom may be located in the United Kingdom. By asking us to provide you with insurance and insurance related services, you consent to the collection, use and disclosure (including overseas disclosure) of your personal information for the purposes described in our Privacy Policy. Where you provide personal information about others, you represent to us that you have made them aware of that disclosure and of our Privacy Policy and that you have obtained their consent. If you do not consent to provide us with the personal information that we request, or withdraw your consent to the use and disclosure of your personal information at any stage, we may not be able to offer you the products or provide the services that you seek. For information about how to access and or correct the personal information we hold about you or if you have any concerns or complaints, ask us for a copy of our Privacy Policy or visit EML at https://www.eml.com.au/privacy/ for a copy of their Privacy Policy.

1. Personal Statement

(i) Name of Claimant: ....

(ii) Address of Claimant: ....

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

(iv) Email Address: ....

(v) Date of Birth: .... (vi) Occupation: ....

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

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

(viii) Telephone Number: .... (ix)Commencement Date: ....

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

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) **Last Statement required** □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): ....

(e) Please attach a Statement from your Accountant confirming your gross weekly earnings for 52 weeks prior to your injury or illness.

(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: ....

(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 No: ....

(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? ....

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

....

....

....

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

....

....

(g) 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:

....

....

....

(h) 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?

....

....

....

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

If yes, please explain why:

....

....

(j) 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:

....

....

....

(k) 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:

....

....

....

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

....

....

....

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

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

....

....

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

If no, please provide details

....

....

....

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

Hospital Name: ....

Date: ....

(p) 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

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

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

(s) 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 (means any part of their usual occupation or business duties)

☐ partially disabled (means modified or reduced (restricted hours) duties)

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

From: .... To: .... (inclusive)

Doctor's Certificate (continued…)

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.

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.

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

Full Name: ....

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Employers Mutual Management Pty Ltd
11 001 735 191

Medical and Information Authority

I authorise any doctor, hospital, therapist or other health professional who has attended me in respect of my illness or injury to release to Employers Mutual Limited (EML) such personal information (including health information) as EML and its associated entities (collectively referred to as "EML" in this document) considers relevant for its assessment of my claim or my entitlement to benefits, including copies of any and all medical records.

I authorise any insurer (including workers compensation/CTP insurer), government body (including Centrelink, Medicare, Comcare and the Department of Veterans' Affairs), employer (including prior employers) or other relevant holder of information to release to EML such personal information (including health information) as EML considers relevant for its assessment of my claim or my entitlement to benefits.

I agree to EML using and disclosing my personal information to my employer, the Policy Holder, other insurers, claims assessors, insurance brokers, underwriting agents, my medical practitioners, my health providers, Medicare, or other parties only for the purposes of managing my claim or as required by law.

I understand that if I do not consent to the terms of this authority or revoke my consent, EML may not be able to process or assess my claim.

Print Name
Signature
Date

Privacy Disclosure

EML is bound by the Privacy Act 1988 (Cth) (Privacy Act), including the 13 Australian Privacy Principles which protect personal information. EML and its subsidiaries respect your right to privacy and value the trust you place in us to handle your personal and sensitive information. Maintaining the privacy of all personal and sensitive information entrusted to us is paramount.

If EML holds personal and health information about you, you may request access to that personal information. However, the law allows us to decline access in limited circumstances. Please direct any request to EML Group's Privacy Officer via email at: privacy@eml.com.au. EML will deal with any access or correction request in a timely manner.