

**INSTRUCTIONS:**

1. You fully complete Sections 1 - 5 of the claim form including the injury statement.  
We cannot proceed with the claim without this information
2. Ensure you sign the privacy declaration (Section 7)
3. **YOUR EMPLOYER** fully completes Section 8 of the claim form.
4. **YOUR DOCTOR** fully completes the two page "Medical Practitioners Statement"
5. Attach a copy of your most recent Payslip to your claim submission.
6. Scan and email the claim form through to [claims@fullertonhealthcs.com.au](mailto:claims@fullertonhealthcs.com.au)

**We cannot proceed with the claim without this information.**

**FAQ's:**

**How long will it take to complete my section of the form?**

This should only take about 10 - 15 mins. We want to settle your claim for you as quickly as we can. If insufficient information is provided or if corrections are required this will likely lead to unwanted delays.

**How can I check the progress of my claim?**

Please contact Fullerton Health Corporate Services on (02) 8256 1770 and advise that your query relates to an Income Protection Claim.

Please provide the claim number you received from the acknowledgement notification.

## CLAIM FORM

### PERSONAL ACCIDENT &/OR SICKNESS

#### IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
3. The issue of this form is not an admission of liability.

#### SECTION 1: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

Employer name		Policy Number	
<input type="text"/>		<input type="text"/>	
Title	Given Name(s)		Gender
<input type="text"/>	<input type="text"/>		<input type="checkbox"/> M <input type="checkbox"/> F
Family Name		Date of Birth	
<input type="text"/>		<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	
Residential Address	Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Do you consent to us communicating with you by email?		Email Address (important)	
Y <input type="checkbox"/> N <input type="checkbox"/>		<input type="text"/>	
		Daytime Contact Number	Alternative Number
		<input type="text"/>	<input type="text"/>
Occupation, Trade or Profession	Work Site / Location		
<input type="text"/>	<input type="text"/>		
For what are you claiming? <input type="checkbox"/> Weekly Benefit <input type="checkbox"/> Capital Benefit <input type="checkbox"/> Non - Medicare Medical Expenses (If applicable)			

#### SECTION 2: EFT AUTHORISATION

I hereby authorise and request that Fullerton Health Corporate Services credit my bank account as indicated below:

Account Holders Name

BSB Number	(6-Digits)	Account Number	Bank
<input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>	<input type="text"/>

**SECTION 3: DETAILS OF INJURY - COMPLETE IF AS A RESULT OF ACCIDENT**

Date of Accident

Time

AM / PM

□	□	□	□	□	□	□	□	□	□	□	□	□	□	□
---	---	---	---	---	---	---	---	---	---	---	---	---	---	---

Address where accident occurred:

Were there any witnesses to the accident?

Yes  No

Witness Name:

Witness Address:

Please describe how the accident / injury occurred:

What were the injuries?

Have you previously been treated from a similar or same injury?

Yes  No

If Yes, please give details:

Give details of any previous claim made for any previous injury against any insurance company: (please attach separate sheet if insufficient)

During the 24 hours before the injury, did you drink any alcohol or take any drugs?  Yes  No

If Yes, please state types & quantities:

Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

When did you stop work? Time AM / PM

When did you first obtain treatment? Time AM / PM

Name of Current Treating Doctor Clinic Name/ Address

Name of Regular Doctor Clinic Name/ Address

First consulted Doctor: 
Last consulted Doctor:

How long have you known this Doctor?  YEARS  MONTHS

**If you have not seen the above Doctor for more than 5 years or have visited other than this Doctor, please provide the Doctors information for the past 5 years (If this is not completed, it may delay your claim):**

Name of Doctor (1) Clinic Name/ Address

First consulted Doctor: 
Last consulted Doctor:

How long have you known this Doctor?  YEARS  MONTHS

Name of Doctor (2) Clinic Name/ Address

First consulted Doctor: 
Last consulted Doctor:

How long have you known this Doctor?  YEARS  MONTHS

Was hospital treatment required?  Yes  No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

Is there any condition (past or present) affecting your current disability?  Yes  No

If Yes, please give details

**Are you now:**

Recovered  Yes  No      When did you return to work?

Partially Disabled  Yes  No      When did you return to work undertaking part of?

Totally Disabled  Yes  No      When do you expect to return to work?

Have you made, or will you make, or are you entitled to make, a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury?  Yes  No

If Yes, please give details

	Claim Number (if known)	Name	Address
Employer			
Workers Comp / Transport Insurer			

Name of your Superfund  Superfund Membership No.

Are you entitled to Income Protection Benefits through your Superfund?  Yes  No

If yes, have you made a claim?  Yes  No      Claim Reference Number:

Are you entitled to claim benefits for this Injury from other Insurers (i.e. Personal Income Protection Insurance), Persons, Company, Health Fund, Friendly Society or Government?  Yes  No

If Yes, please give details

Name	Address



## Fullerton Health Corporate Services (FHCS)

FHCS is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). FHCS will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

FHCS will take all reasonable steps to ensure that personal information held by FHCS is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

FHCS has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at [www.fullertonhealth.com.au](http://www.fullertonhealth.com.au) and send to [privacy@fullertonhealthcs.com.au](mailto:privacy@fullertonhealthcs.com.au)

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

## Medical Authority and Declaration

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

I agree to FHCS using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to FHCS'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 FHCS's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to FHCS such personal information (including health information) as FHCS in 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 cooperation to FHCS 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 if I do not consent to the terms of this authority or revoke my consent, FHCS may not be able to process or assess my claim.

I appoint FHCS 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 (any adult person):

Date:   |   |

Name of Witness:

**WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME**

Employers Name:

This is to Certify that:  has been unable to attend his/her occupation as a result of Injury or Sickness

From:         Until:

His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was: AUD \$:

**PLEASE ATTACH THE EMPLOYEE'S PAY HISTORY FOR THE 12 MONTHS PRIOR TO THEIR LAST DAY AT WORK**

Employee's Occupation:

Type of Employment: Permanent Full Time  Permanent Part Time  Casual  Fixed Term/Contract

Are they still employed:  Yes  No If no, please provide the last date they were employed:

His / Her sick leave entitlement as at the date of injury. Days:

He/She has been employed since: Date:

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/CTP?  Yes  No

**SIGNATURE OF SUPERVISOR or MANAGER:**

**NAME OF SUPERVISOR or MANAGER:**   
**(PLEASE PRINT)**

**TELEPHONE NUMBER:**

**DATED:**



The claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly

Patients Name

DOB:

Height:

Weight:

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

Cause:

Is this condition  an injury  an illness

Does the patient have any other injury or illness that is contributing to the condition?  Yes  No

Provide Details

Is condition due to injury or sickness arising out of the patient's employment?  Yes  No

Provide Details

Was the disability sports related?  Yes  No

Provide Details

Date of onset/first symptoms?

When did the patient first consult you for this condition?

Has the patient ever had the same or similiar condition?  Yes  No

From when & diagnosis:

Name of patient's usual doctor/medical practice :

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

If the patient been hospitalized please provide;

Admission Date

Discharge Date

Name of Hospital

Has the patient had surgery or is it anticipated?  Yes  No

Provide Details

Date performed or anticipated:

Give name of hospital:

Please outline all treatment received to date in the management of your patient's condition. Please include any relevant medical documents, reports or investigative scans.

Was the patient referred by you or to you?

Yes  No

Provide Details

Doctors details

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

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?

Yes  No

Name of Company/Contact/Claim Number:

Signature of medical practitioner:

Date:

Name + Qualifications (print):

Address:

Telephone:

## WHAT TO DO WHEN FORM IS COMPLETE

- 1 Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employers and Medical Practitioner have signed this form.
- 2 Send this form to:

Fullerton Health Corporate Services  
Level 10, 33 York Street, Sydney NSW 2000, or Fax 61 2 8256 1775 or  
[claims@fullertonhealthcs.com.au](mailto:claims@fullertonhealthcs.com.au)

## DISPUTES

Fullerton Health Corporate Services has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.

Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.

If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access to the applicable insurer's Internal Dispute Resolution Committee who can review Your complaint.

If You or an Insured Person are still dissatisfied, the complaint may be referred, at no cost to you, to the Financial Ombudsman Service operated by Financial Ombudsman Service Limited under the terms of the General Insurance Code of Practice.