



Personal Accident & Sickness Claim Form

PLEASE ANSWER QUESTIONS FULLY, USE BLOCK LETTERS AND TICK APPROPRIATE BOXES.
IF INSUFFICIENT SPACE, PLEASE ATTACH SUPPLEMENTARY PAGES ON YOUR LETTERHEAD

IMPORTANT:
In the event of the occurrence of any Event in respect of which a claim has arisen or may arise soon thereafter, please complete the following Claims Notification form, carrying out the following procedures and send to the address below:
Aurora Underwriting Agency Pty Ltd Suite 502, Level 5, 54 Miller Street, North Sydney NSW 2060 P.O. Box 893 North Sydney NSW 2059

1.	CLAIMANT DETAILS		
1.1	Full Name of the Claimant:		
1.2	Residential Street Address:		
	Phone No.:		Mobile No.:
1.3	Occupation:		
1.4	Describe your usual duties:		
1.5	Date of Birth:	/ /	Sex: M <input type="checkbox"/> F <input type="checkbox"/>
1.6	Height:	cm	Weight: kg
1.7	Name of Your Employer/ Principal Contractor:		
1.8	Employer's Address:		
	Employer's Phone Number:		
	Tick box if there are attachments <input type="checkbox"/>		

ACCIDENT CLAIM

2.	DETAILS OF THE ACCIDENT CAUSING INJURY		
2.1	Date of Accident:	/ /	Time of Accident: am/pm
2.2	Where did the accident occur?		
2.3	Please give a FULL description of the accident and how you sustained your injury(ies):		
2.4	Did the Police attend the accident?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please give details below:		
	(i) Police Station:		
	(ii) Attending Officer's Name:		
	(iii) Police Case Ref No.:		
2.5	Were you under the influence of any drugs or alcohol at the time of the injury/accident?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please give details, including any readings that were taken (<i>attach a copy of any reports to this claim form</i>)		
2.6	When did you first consult a doctor for your injury?		
	Date:	/ /	Time: am/pm
2.7	Please give details of all the doctors that attended you:		
	Doctor's Name	Address	Phone Number
2.8	When did you first become unable to work from the injury(ies) you sustained in the accident?		
	Date:	/ /	Time: am/pm
2.9	If you are still disabled, when do you expect to return to work?		
	Date:	/ /	Time: am/pm

2.10	If you were admitted to a hospital, or treated as an outpatient, please give details:			
	Name of Hospital:			
	Date/Time Admitted	am/pm	Date/Time discharged	am/pm
	Inpatient or Outpatient?			

2.11	Please give details of your usual doctor:			
	Doctor's Name	Address	Phone Number	
2.11	Have you ever been in a similar condition in the past?			Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please give details:			
	Condition	Treating Doctor	Phone Number	Date First Treated
	Tick box if there are attachments <input type="checkbox"/>			

SICKNESS CLAIM

3.	DETAILS OF THE SICKNESS		
3.1	What sickness or condition are you suffering from?		
3.2	When did you first become aware of the sickness or condition?		
	Date:	/ /	Time: am/pm
3.3	What date did you first seek medical treatment for the sickness or condition?		
	Date:	/ /	Time: am/pm
3.4	Have you suffered from the same or similar condition in the past?		Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please provide details below:		
	Doctor's Name and Address		
	Phone Number:	Fax Number:	
	Dates of Treatment:	From: To:	
3.5	On what date were you first unable to attend to the usual duties of your work?		
	Date:	/ /	Time: am/pm
3.6	How long do you expect to be off work from this sickness or condition?		days/weeks
3.7	If you are still disabled, what date do you think you will be able to return to work?		date
3.8	Have you been advised to cease treatment for this sickness or condition?		Yes <input type="checkbox"/> No <input type="checkbox"/>
3.9	What are the contact details of the treating doctor(s) you have consulted for this sickness or condition?		
	Doctor's Name and Address		
	Phone Number:	Fax Number:	
	Dates of Treatment:	From: To:	
	Doctor's Name and Address		
	Phone Number:	Fax Number:	
	Dates of Treatment:	From: To:	
	<i>If there is not enough space, please attach a separate sheet.</i>		

3.10	Please give details of your usual doctor:		
	Doctor's Name and Address		
	Phone Number:		Fax Number:
	Dates of Treatment:	From:	To:
	<i>If there is not enough space, please attach a separate sheet.</i>		
3.11	What is the current treatment you are receiving for this sickness or condition? (medication, physio etc.)		
	Tick box if there are attachments <input type="checkbox"/>		
3.12	What duties of your usual occupation are you able to perform with this sickness or condition?		

4.	OTHER INSURANCE	
4.1	Do you have any other insurance policy that provides weekly benefits in the event of an injury or sickness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please give name of insurance company:	
4.2	Do you have any other insurance policy that provides lump sum benefits in the event of an injury or sickness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please give name of insurance company:	
4.3	Are you entitled to make a claim under any other insurance or compensation scheme in respect of your injury or sickness?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please give details of who you could claim from (workers compensation, transport accident authority, etc.) and their contact details:	
4.4	Have you ever had an injury or sickness claim before?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please provide details:	
	Tick box if there are attachments <input type="checkbox"/>	

5.	MEDICAL AUTHORITY AND DECLARATION BY CLAIMANT		
	This declaration must be completed and signed by or on behalf of all parties applying for insurance.		
5.1	I hereby authorise any hospital, physician, insurer, health insurance commission, employer or any other person who has attended me to supply Aurora Underwriting Agency or its representative with any and all information with respect to any injury or sickness, medical history, consultation, prescriptions or treatment, including copies of all my hospital and/or medical records. I agree that a photocopy or facsimile copy of this authorisation shall be considered as effective and valid as the original.		
5.2	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 claim, 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, present or future claims will be forfeited.		
	Name		
	Signature		Date / /

Request for payment by Electronic Fund Transfer

Account Name: _____

BSB: _____

Account No. _____

Signature: _____

6.	EARNINGS DECLARATION		
	TO BE COMPLETED BY YOUR EMPLOYER OR PRINCIPAL CONTRACTOR		
6.1	Employers Name		
6.2	Address		
6.3	Phone Number:		
6.4	What is the claimant's gross weekly earnings (average over last 12 months)	\$	
6.5	Is the employee entitled to Workers' Compensation Benefits? IF YES	Yes <input type="checkbox"/> No <input type="checkbox"/>	
	(a) What is the Workers' Compensation Weekly Benefit:	\$	
	(b) Can you please provide copies of all relevant Workcover correspondence		
6.6	Was the claimant employed by you on the date of the accident or sickness?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
6.7	This employee has been employed since:	/ /	
6.8	Your Name:		
6.9	Your position at the Company:	Phone No.:	
6.10	Signature	Date:	
	Tick box if there are attachments <input type="checkbox"/>		

7.	MEDICAL PRACTITIONERS STATEMENT - to be completed by your Doctor			
7.1	Patient's Name:			
7.2	Patient's Date of Birth:	/	/	Patient's Sex: M <input type="checkbox"/> F <input type="checkbox"/>
7.3	What is your diagnosis of the patient's condition?			
7.4	What date did you first consult with the patient regarding this condition?			
	Date:	/	/	Time: am/pm
7.5	To your knowledge, do you know what date the patient first obtained medical treatment or advice in relation to this condition?			
	Date:	/	/	Time: am/pm
7.6	Has the patient ever suffered a similar condition, and if so does it relate to his/her present condition?			Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please provide details:			
7.7	Has the patient told you they were under influence of alcohol or drugs at the time of the injury?			Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, was a blood alcohol test taken?			Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, what were the results:			
7.8	How long has the patient attended your practice?	Years	months	Not before <input type="checkbox"/>
7.9	What treatment is the patient receiving for this condition?			
7.10	Please provide any relevant medical history that will assist us with the patient's claim:			
7.11	What investigations have been made in determining a diagnosis for this patient's condition?			

7.12	Are you the patient's regular treating doctor?			Yes <input type="checkbox"/> No <input type="checkbox"/>
	If No, please advise name and number of patient's regular treating doctor:			
7.13	Do you consider the patient to be wholly and continuously prevented from engaging in his/her usual occupation as a result of this condition?			Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please specify the period:	From:	To:	
7.14	Do you consider the patient to be able to carry out a substantial part of his/her usual occupation as a result of this condition?			Yes <input type="checkbox"/> No <input type="checkbox"/>
	If Yes, please specify the period:	From:	To:	
7.15	On what date do you consider the patient will be able to return to work:			/ /
7.16	Name:		Qualifications:	
	Phone Number:		Fax No:	
	Email:			
	Address:			
	Signature:		Date:	
	Tick box if there are attachments <input type="checkbox"/>			