



PERSONAL ACCIDENT & SICKNESS

Important Notice

This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.

This form can be completed electronically. If completing this form by hand: Please print.

The issue of this form is not an admission of liability.

Once completed please either email or mail the claim form to Fullerton Health Corporate Services.

Instructions

1. You **fully** complete Sections 1 - 5 of the claim form including either the illness or injury statement. We cannot proceed with the claim without this information
2. Ensure you sign the Privacy Declaration (Section 7)
3. For the Self Employed, please provide your Tax Assessment advice from the ATO for the previous financial year as proof of your income
4. For Employees, please have your Employer fully complete Section 8 of the claim form and include 12 months payroll history prior to the date of disablement
5. Your Doctor completes the "Medical Practitioner's Statement"
6. Scan and email the claim form through to **liberty@csnet.com.au**

1. POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

Employer's name		Policy no	
Title	Given name(s)	Male	Female
Family name		Date of birth	
Residential address			
Suburb		State	Postcode
Postal address			
Do you consent to us communicating with you by email?	Yes	No	Email
Daytime contact number		Alternative number	
Occupation, trade or profession			
Work site/location			
For what are you claiming?	Weekly benefit	Capital benefit	Death benefit

2. EFT AUTHORISATION

Please tick preferred method of Payment for refund. Direct/EFT payment or Cheque
 I hereby authorise and request that Corporate Services Network credit my bank account as indicated below

For Direct/EFT payment

Account holder's name		
BSB no	Account no	Bank

For Cheque payment

Payee

3. DETAILS OF INJURY – COMPLETE IF AS A RESULT OF ACCIDENT

Date of accident	Time	AM	PM
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Address where accident occurred

Were there any witnesses to the accident?	Yes	No
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Witness name

Witness address

Please describe how the accident/injury occurred

What were the injuries?

Have you previously been treated for any serious 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

4. TO BE COMPLETED IF DISABILITY IS AS A RESULT OF AN ILLNESS/SICKNESS

The nature of illness

When did the illness begin?

Have you had this complaint before?

Yes

No

If Yes, when

and how long were you disabled?

5. TREATMENT RECEIVED FOR INJURY/ILLNESS

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

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)

Doctor's name	Address	Telephone number

When did you stop work? Time AM PM

When did you first obtain treatment from doctor? Time AM PM

Name of doctor

Address

Is this doctor still treating you for the injury/illness? Yes No

Is this doctor your regular doctor? Yes No

If No, please give details

Name of regular doctor

Address

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, a claim for benefits under any Worker's Compensation Act or Transportation Act because of this injury? Yes No

If Yes, please give details

	Claim no (if known)	Name	Address
Employer			
Worker's Comp/ Transport Insurer			

Are you entitled to claim benefits for this Injury/Illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? Yes No

If Yes, please give details

Name	Address

6. TO BE COMPLETED BY PERSON MAKING A CLAIM FOR DEATH BENEFIT

Name of person completing the form _____

Telephone _____ Email _____

Company name (if applicable) _____

Address _____

Relationship with deceased Employer Next of kin Executor Family doctor Lawyer Other

If next of kin, state relationship

The following items must be included with this claim.

- Certified copy of Death Certificate
- Certified copy of Original Birth Certificate
- Copy of the Coroner's Depositions & Findings (if applicable)

Was a coronial inquest held or is one being held? Yes No

If so, give details below

7. MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither Corporate Services Network (CSN) or Liberty Specialty Markets (Liberty) have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN or Liberty using and disclosing my personal information pursuant to their 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 CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN or Liberty such personal information (including health information) as CSN or Liberty 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 CSN 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, CSN or Liberty may not be able to process or assess my claim.

I appoint CSN 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

Privacy Notice

Liberty Specialty Markets (Liberty) and Corporate Services Network (CSN) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and CSN collects personal information in order to provide claim assessments and insurance related services. Liberty and CSN may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, UK, Singapore, Hong Kong and Malaysia.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from Liberty and CSN. If you do not provide the personal information Liberty, CSN or other relevant third parties require to offer you specific products or services, Liberty or CSN may not be able to provide the appropriate type or level of service.

If you wish to gain access to or correct your personal information, make a privacy complaint, or if you have any query about how Liberty or CSN collects or handles your personal information please write to Liberty's Privacy Officer at privacy.officer.ap@libertyglobalgroup.com or call +61 2 8298 5800 and/or CSN's Privacy Officer at privacy@csnet.com.au or call +612 8256 1770.

To obtain a copy of Liberty's Privacy Policy go to Liberty's website (libertyspecialtymarkets.com.au) or request a copy from Liberty's Privacy Officer. To obtain a copy of CSN's Privacy Policy go to CSN's website (csnet.com.au) or request a copy from CSN's Privacy Officer.

When you give Liberty or CSN personal or sensitive information about other individuals, Liberty and CSN rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.

8. TO BE COMPLETED BY YOUR EMPLOYER

Employer's name _____

This is to Certify that _____
 has been unable to attend his/her occupation as a result of injury or illness

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 injury/illness was _____

Has your employees last 12 months payroll history been attached with this report, and if not please provide Yes No

His/Her sick leave entitlement as at the date of injury or illness _____ Days

He/She has been employed since _____

Please confirm if he/she are still an employee Yes No

Please confirm date they were no longer employed _____

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 _____ Date _____

MEDICAL PRACTITIONER'S STATEMENT TO COMPANY

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

Patient's name	Date of birth
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 illness 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 similar 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 was hospitalised 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? Referred Referring

Provide details

Doctor's 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, Worker's Compensation insurer, Social Security, sports body or any other insurance body? Yes No

Name of Company/Contact/Claim Number

Signature of medical practitioner

Name and qualifications (print)

Address

Telephone