CHUBB

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It's never been easier to do business with Chubb Accident & Health

Personal Accident & Sickness, Voluntary Workers and Group Journey Insurance - Claim Form

COMPLETING THIS CLAIM FORM

- If you have insufficient space to complete any of your answers, please attach a separate signed and dated sheet and identify the question number concerned.
- Notice in writing must be sent to the company within 30 days from the loss occurrence, or the claim may not be recognised.
- This form may be completed if you are claiming under a Personal Accident & Sickness, Voluntary Workers Insurance and Group Journey Accident Insurance.
- The section headed Medical Certificate is required to be completed by the attending Physician.
- Please return completed form to: Chubb Insurance Company of Australia Limited
  Email: aus.ahclaims@chubb.com
  Post: PO Box 20336, World Square Post Office, NSW, Australia, 2002
  Phone: 1300 795 779

A. YOUR INFORMATION

Policy number:	93101214	Policyholder:	The Scout Association of Australia - NSW Branch		
Surname:		First Name:		Title:	
Address:				Postcode:	
Date of Birth:		Sex (M/F):		Marital Status:	
No of Dependents:					
Telephone (Home):		Business:		Mobile:	
Email:					
Employer's Name:		Telephone:			
Address:				Postcode:	
Were you employed at the time of suffering the accident or contracting the sickness?		☐ Yes	☐ No		
If No, provide full details below:					

B. ACCIDENT

Location where accident occurred:			
Date of Accident:		Time:	
What were you doing?			
How did it occur?			
Nature and extent of injuries:			
Have you ever suffered from this type or a similar type of injury?	☐ Yes	☐ No	
If Yes, provide full details:			

C. SICKNESS

When did the sickness commence?	
Nature of sickness:	
How did you get this sickness?	
Have you ever suffered from this sickness or a similar type of sickness?	☐ Yes ☐ No
If Yes, provide full details below:	

D. PERIOD OFF WORK

Provide date and time of your first medical consultation for this Accident / Sickness:

Date:		Time:		On what date did you last work?	

Have you been able to engage in any other occupation following your Accident / Sickness?	☐ Yes ☐ No
If Yes, provide full details below:	
Have you been able, since the Accident / Sickness occurred, to attend in any way to your business / employment or any portion of it?	☐ Yes ☐ No
If Yes, provide full details below:	
On what date did you return to work?	

Name and contact details of Medical Practitioner who attended this condition:

Name:			
Address:		Postcode:	
Telephone Number:			

Name and contact details of your regular Medical Practitioner:

Name:			
Address:		Postcode:	
Telephone Number:			

E. PREVIOUS MEDICAL HISTORY

What other medical or surgical advice, treatment or attention have you received during the past five years? (Give dates, nature of injury or sickness and names and addresses of all doctors, hospitals and clinics). Please answer fully – dashes are not acceptable.

Date	Nature of Injury or Sickness	Names	Addresses

F. GENERAL PARTICULARS

Your policy contains certain 'Lifestyle Protection Benefits'. These may include Benefits such as Accommodation and Transport Benefits, Domestic Help Benefit, Rehabilitation Benefit and certain Out of Pocket Expenses. Do you wish to claim for any particular Benefit as outlined in your Policy wording?	☐ Yes ☐ No
If Yes, provide details below:	
Are you insured elsewhere for accident and/or sickness?	☐ Yes ☐ No
If Yes, provide Name and contact details of Insurer:	
Name:	
Address:	Postcode:
Telephone:	
Have you lodged a claim under Work Cover / Workers Compensation / Compulsory Third Party Insurance?	☐ Yes ☐ No
If Yes, provide name and contact details of Insurer:	
Name:	
Address:	Postcode:
Telephone:	
Status of Claim:	
Are you entitled to sick leave? ☐ Yes ☐ No	If Yes, please advise number of days:
Period you have received sick leave:	From: To:
If you are claiming weekly benefits, please provide your gross basic salary (excluding bonuses, commission, overtime payments and other allowances) averaged over one (1) year immediately preceding the Accident / Sickness :	$
Please note: A copy of your last three payslips or tax statement will also be required.	

G. AUTHORITY TO GIVE INFORMATION

I/we hereby authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the insurer such information as it may require regarding any injury or illness to me or my physical or mental condition or prognosis, or my employment, to assist in the proof and settlement of my claim. A photocopy of this authority can be acted upon as if it were original.

Signature:		Date:	
Note:	The issuing or the receipt of this claim form is not to be construed as an admission of liability on the part of Chubb Insurance Company of Australia Limited.		

H. CLAIM PAYMENT DETAILS - ELECTRONIC FUNDS TRANSFER

For fast payment of claims, please provide your bank account details below:			
Name of bank:			
Account name:			
BSB:		Account No:	
For international payment the Bank Swift Code:			
Bank address:			
If paying into overseas bank, what currency is the account in? (e.g. USD)			

I. PRIVACY AND CLAIM DECLARATION

Provision of Health Insurance

Chubb cannot provide cover or benefits under Medicare or private health insurance laws or regulations in Australia including the Health Insurance Act 1973 (Cth), Private Health Insurance Act 2007 (Cth) and Private Health Insurance (Health Insurance Business) Rules 2010 or any successor legislation.

Your Privacy

In the course of providing insurance and processing insurance claims, we need to collect Personal and Sensitive Information as defined in Privacy Act 1988 (the Act) about persons that we insure and persons associated with persons we insure. In accordance with the Act our privacy policy contains the information required to be given to persons about whom we collect Personal and Sensitive Information and how you may access your personal or sensitive information held by us.

Your Access to Your Personal and Sensitive Information

You can request access to Personal and Sensitive Information, which we hold about you. Your rights to access and our rights to refuse access are set out in the Act. You have a right to access any personal or sensitive information we hold about you on written request, unless one or more of the exceptions to the APPs apply.

Our Use of Personal and Sensitive Information

We may at any time use Personal and Sensitive Information we collect about you to provide a quotation or assess a proposal for insurance, to provide, amend or renew an insurance policy and to respond to a claim.

Our Disclosure of Personal and Sensitive Information

We may at any time disclose Personal and Sensitive Information we collect about you to the following types of organisations (some of which may be outside Australia). These include re-insurers; external valuers and appraisers; loss adjustors and other investigators; professional advisers, such as accountants and lawyers; and other organisations that provide services to us in relation to the provision of insurance. To assist us in providing insurance services to You, We may transfer Personal and Sensitive Information overseas to the types of organisations listed above in Canada, China, Hong Kong, India, Singapore, Thailand, the United Kingdom and the United States of America. Where we do so, we take reasonable steps to ensure it is kept confidential.

Consent

You consent and authorise us to collect, use, store and disclose personal or sensitive information provided either directly by you or your representative or agent in accordance with the Act. Where personal information is provided to us by a person, other than yourself, you agree that all necessary consents to collect, use, store and disclose that personal or sensitive information to us have been made or given. Our privacy policy is readily available on our website www.chubbinsurance.com.au. Alternatively, please contact us if you would like a copy.

Declaration

I/We do hereby declare that the foregoing answers are true and correct. I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to claim could be forfeited.

Signature:		**Date:**	

CHUBB

www.chubbinsurance.com.au
Chubb Insurance Company of Australia Limited
ABN 69 003 710 647 AFS License Number 239778

Branch Offices	Address	Telephone
Brisbane	Level 13, 40 Creek Street, Brisbane QLD 4000	(07) 3227 5777
Melbourne	Level 14, 330 Collins Street, Melbourne VIC 3000	(03) 9242 5111
Perth	Level 1, 225 St Georges Terrace, Perth WA 6000	(08) 6211 7777
Sydney	Level 29, 2 Park Street, Sydney NSW 2000	(02) 9273 0100

J. MEDICAL CERTIFICATE / CERTIFICATE OF ATTENDING PHYSICIAN

(To be completed by attending Physician)

The claimant must obtain, at their own expense, the completion of this certificate from a duly qualified and registered medical practitioner. In the event of the medical practitioner being unable to answer from their own personal knowledge any of the following questions, they are requested to state so.

Furnished in connection with the disability of:

Name of Patient:					
Address:				Postcode:	
Are you the patient's regular physician?				☐ Yes	☐ No
If Yes, how long have you known the patient?	Years:		Months:		
Complications:					
Has the patient previously suffered from the same or similar injuries / sicknesses?				☐ Yes	☐ No
If Yes, provide the date and diagnosis:					
Date of first consultation of this condition:					
In your opinion, how long has this condition been in existence whether treated for same or not?					
Present condition:					
Prognosis:					
Nature of operation (if any):					

Name of Physicians who previously treated patient for above condition:

Name:		Name:	
Are the patient's symptoms:	☐ due exclusively to the accident,	☐ traceable to disease,	☐ infirmity or any other cause?
Is there anything in the patient's medical history which may have contributed, directly or indirectly, to the injury / illness or which may be likely to retard the patient's recovery?		☐ Yes	☐ No

If yes, provide details below:

Is the patient still under your care for this condition?				☐ Yes	☐ No
If No, on what date did you release the patient to perform regular duties:					
Dates unfit for work, or unable to perform specific parts of the patient's occupation:	From:		To:		

Please note: If uncertain, please estimate.

Have you any reason to suppose that the patient was under the influence of intoxicants or drugs at the time of the accident?				☐ Yes	☐ No
If hospitalised, give dates:	From:		To:		
Name of Hospital:					
Give dates patient was totally disabled	From:		To:		
In your opinion, probable further disability should not exceed:			Date:		
Name of Physician:					
Address:				Postcode:	
Telephone:		Qualifications:			
Signature:		Date:			