CHUBB INSURANCE COMPANY OF AUSTRALIA LIMITED
ACN 003 710 647

CLAIM No _____

_____

POLICY No _____

_____

Claim Form
Personal Accident and Sickness

(This Issue of this Form is not an Admission of Liability by Chubb Insurance Company of Australia Limited

BRANCH:

ADDRESS:

Notice in writing must be sent to the company within 30 days from its occurrence, or the claim may not be recognised. Please complete this form and return it to Chubb Insurance within that time period.

Important Note: The Section headed Medical Certificate is required to be completed by the attending Physician.

Surname _____ Other Name _____ Mr, Mrs
Miss, Ms _____

Address _____

_____ Postcode _____

Date of Birth _____/___/___ Sex (M/F) _____ Marital Status _____

Place of Birth _____ Occupation _____

Telephone Home _____ Business _____

Employer's Name _____ Telephone No _____

Address _____ Postcode _____

Were you employed at the time of suffering the accident or contracting the sickness? ☐ Yes ☐ No

If No, provide full details: _____

_____

_____

Was your employment ☐ Full time ☐ Part time ☐ Temporary Length of Service _____

SECTION A - ACCIDENT

Location where accident occurred _____

Date of Accident _____/____/____ Time _____ am/pm

What were you doing? _____

How did it occur? _____

Nature and extent of injuries _____

Have you ever previously suffered from this type or a similar type of injury? ☐ Yes ☐ No

If Yes, provide full details: _____

_____

SECTION B - SICKNESS

Have you ever had this Sickness before? ☐ Yes ☐ No If Yes, so when? _____

Have you ever had this Sickness before? Yes No If Yes, so when?_____

_____

Nature of sickness _____

How and when 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: _____

_____

_____

PERIOD OFF WORK

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

Date _____/_____/_____ Time _____ am/pm

On what date did you last work? _____

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: _____

_____

_____

_____

Have you been able to engage in any other occupation following your Accident/Sickness? ☐ Yes ☐ No

If Yes, provide full details: _____

_____

_____

_____

I am now disabled ☐ Wholly ☐ Partially ☐ Not at all

On what date did you return to work? ____/____/____

If still disabled, state how much longer disability is likely to continue _____ weeks

Name and Address of Medical Practitioner who attended this condition

Name _____ Address _____

_____ Postcode _____

Name and Address of your regular Medical Practitioner

Name _____ Address _____

_____ Postcode _____

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	Address

GENERAL PARTICULARS

Are you insured elsewhere for Accident or Sickness?

If Yes, provide Name and Address of Insurer

Name _____ Address _____

_____ Postcode _____

Have you lodged a claim under Work Cover / Workers' Compensation / Compulsory Third Party insurance? ☐ Yes ☐ No

If Yes, provide Name and Address of Insurer

Name _____ Address _____

_____ Postcode _____

Status of Claim _____

Are you entitled to sick leave? ☐ Yes ☐ No

If Yes, please advise number of days or

Period you have received sick leave From _____ To _____

If you are claiming weekly benefits

Please provide your gross basic salary (excluding bonuses, commission, over-time payments and other allowances) averaged over the calendar year immediately preceding injury/sickness

$

I hereby declare that I am suffering or have suffered from the injury or sickness abovenamed and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to compensation could be forfeited.

Signature of Claimant _____ Address _____

_____ Postcode _____

Date ____/_____/____

AUTHORITY TO GIVE INFORMATION (To be signed by the Claimant)

I 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 underwriter such information as it may require regarding any illness and/or injury 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 or xerography copy of this authority can be acted upon as if it were original.

Signed _____ Date ____/____/_____

Note: The issue of acceptance of this form is not to be construed as an admission of liability on the part of Chubb Insurance Australia.

MEDICAL CERTIFICATE **(**To be completed by the attending Physician)

The claimant must obtain, at his 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 his own personal knowledge any of the following questions, he is requested to state so.

CERTIFICATE OF ATTENDING PHYSICIAN

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 injury/sickness?
If yes, provide the date and diagnosis ☐ Yes ☐ No

Diagnosis _____

_____ Date ___/____/____

Date of first consultation for this condition Date ____/____/____

How long has this condition, in your opinion, been in existence whether treatedfor same or not?

_____

Present Condition _____

Prognosis _____

Nature of Operation (if any) _____

Name of Physicians who previously treated patient for above condition

Name _____ Name _____

Are patient's symptoms ☐ due exclusively to the accident, or ☐ 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?_____

Is patient still under your care for this condition? ☐ Yes ☐ No

If not, on what date did you release patient to perform regular duties Date _____/_____/_____

Dates partially unfit for work (unable to perform specific parts of the patient's occupation):

From _____ To _____ (Both dates inclusive)

Dates partially unfit for work (unable to perform specific parts of the patient's occupation):

From _____ To _____ (Both dates inclusive)

If uncertain, please estimate: Totally Unfit to (date) _____ Partially Unfit to (Date) _____

Have you any reason to suppose that the patient was under the influence of
Intoxicants or drugs at the time to 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 _____
weeks/months

From the _____

Name of Physician _____ Address _____

_____ Postcode _____

Phone Number _____ Qualifications _____

Signature _____ Date ____/_____/_____