DUAL Personal Accident

Claim Form

The issue of this form is not an admission of liability

Please Ensure

- You complete Sections 1 - 5 in full and then submit this Claim Form to your employer to complete Section 6 and your doctor to complete Section 7.
- You have enclosed all requested information/documentation.
- You have signed this Claim Form.
- All Medical Certificates must state the reason for your disablement (e.g. 'medical condition' cannot be accepted).

Section 1 - Claimant Details

Certificate / Policy No:

Name of Insured / Employer:

Claimant Given Name and Family Name:

Date of Birth:

Address of the Insured:

Occupation:

Telephone No.:

Mobile No.:

Email:

Do you consent to us communicating with you by email? Yes ☐ No ☐

Section 2 - Claims For Injury / Sickness / Death

What is the injury or sickness?

If injured, how exactly did it occur?

Do you consider your injury to have been caused by your work? Yes ☐ No ☐

When did the injury occur, or the sickness begin or first manifest itself or when was it first diagnosed?

Date:

Did the injury or sickness cause you to stop work? Yes ☐ No ☐

If YES, please provide the following details:

Date:

Are you a part time or casual employee? Yes ☐ No ☐

Have you returned to work full-time? Yes ☐ No ☐

If YES, please provide the following details:

Date:

Have you returned to work part-time? Yes ☐ No ☐

If YES, what hours are you working?

Days: Hours:

Details of your usual pre-injury Duties:

Are you currently on a claim for any injury or sickness not including this claim? Yes ☐ No ☐

If YES, please provide the following details:

Date:

Who is your usual family doctor?

How long have you been treated by your family doctor?

Name:

Address:

Telephone Number:

When did you first get treatment from a medical practitioner for this condition?

Doctors Name:

Address:

Telephone Number:

When did you first see the medical practitioner?

Date:

Were you hospitalised for this condition? Yes ☐ No ☐

If YES, please provide the following details:

Date: to

At which Hospital?

Detail surgery performed:

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

State Types and Quantities:

Have you ever suffered this injury/sickness or a similar condition before? Yes ☐ No ☐

Give details:

Are you affected by any long term or chronic disability? Yes ☐ No ☐

Give details:

Section 3 - Other Insurance / Benefits

Are you entitled to claim compensation from your Superannuation Fund or any insurance through your Superannuation Fund?

Member number:

Are you entitled to claim insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, sports body or any Income Replacement, Private Health Insurance?

Give details:

Name of organisation / Insurer:

Name of Insurer and Contact Details:

Type of Cover:

Claim Number:

Amount Claimed:

Attach a copy of the claim acceptance letter, Benefit Statement, other correspondence.

Section 4 - Bank Account Details

Please complete the following:

Bank:

Account Name(s):

BSB Number: - - -

Account Number:

Declaration

Claim Lodgement Details

Please forward claim details using one of the following lodgement processes

(Please keep a copy of all documents sent to CSN)

Postal Address:

Corporate Services Network
GPO Box 4276
Sydney, NSW 2001

Email Address:

claims@csnet.com.au

Fax No:

+61 2 8256 1775

Phone Number:

Once the claim form has been completed, sent, and received by CSN, claim inquiries can be made to CSN on:
+61 (2) 8256 1770
Policy and coverage queries should first be directed to your Insurance Broker.

Privacy Collection Statement:

We are committed to protecting your privacy and complying with the *Privacy Act 1988* (Cth) ('Privacy Act').

We use your information to assess the risk of providing you with insurance, provide quotations, issue policies and assess and manage claims, on behalf of the insurers we represent. If you do not provide us with full information, we may not be able to provide insurance or assess and manage a claim. If you provide us with information about someone else, you must obtain their consent to do so.

We may provide your personal information to the insurer we represent, insurance regulators and other insurance bodies as required by law. We may also provide your information to your broker and any third party claims service providers (such as claims management companies, parties repairing or replacing the subject matter, loss adjusters and appointed law firms (and the like)). If a recipient is not regulated by laws which protect your information in a way that is similar to the Privacy Act, we will take reasonable steps to ensure that they protect your information in the same way we do or seek your consent before disclosing your information to them. We do not trade, rent or sell your information.

Our Privacy Policy contains more information about how to access and correct the information we hold about you and how to make a privacy related complaint, including how we will deal with it. By providing us with your personal information, you consent to its collection and use as outlined above and in our Privacy Policy. Ask us for a copy of our Privacy Policy via email at privacy@dualaustralia.com.au or access it via our website using the following link.

Declaration and Authorisation Complete for all Claims

- I declare that the information in this form and any documents attached to it, is correct and complete and that I have not withheld any information that could affect this claim. I understand that any false statement or information may lead to my claim being denied.
- I also understand and accept that until I provide all required information, consent and authorities DUAL will not be able to process my claim and will have no obligation to make any payment to me or on my behalf.
- I authorise any hospital, physician or other person who has attended to me to furnish to DUAL and the claims manager, Corporate Services Network (CSN), or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, and copies of all hospital or medical reports.
- I authorise any Insurer, organisation or body through which I am claiming similar benefits to furnish to DUAL and CSN all information with respect to this Sickness or Injury to enable assessment of my claim.
- I declare that should any information provided in this form alter after the date of this declaration, I will give immediate notice thereof to CSN.
- I agree that CSN and the Underwriters may use and disclose my personal information in accordance with the 'Privacy Collection Statement' at the end of this Claims Form.
- I agree that a photocopy of this declaration shall be considered as effective as the original.

Insured(s)

Position:

Signature:

Date:

Section 6 - Employer or Principal Contractor Statement

Claimant Name:

When did Claimant cease working for this Injury/Sickness?

Date:

Is the claimant currently off work on an unrelated claim? Yes ☐ No ☐

Date of employment with the Company:

Gross Weekly Salary averaged over the last 12 months prior to the date of disablement (Please attach pay report):

$

Did the Injury occur at work? Yes ☐ No ☐

If so when will/was the Workers' Compensation Claim lodged? Date:

If YES, what is the Weekly Compensation?
(Please attach all WorkCover correspondence)

What payments have been made to date during the period of disablement?

WorkCover $ From To

Normal Pay $ From To

Sick Pay $ From To

What is the usual occupation of the claimant?

What are his/her usual duties?

Has the Claimant returned to work? Yes ☐ No ☐

If YES, please provide the following details:

Date:

Name of Company:

Contact Details:

Address:

Telephone Number:

Email:

Employer's Signature

Signature:

Name:

Position:

Section 7 - Doctor's Statement

This section must be fully completed by attending doctor - any fee for completion of this section is the responsibility of the insured person

Patient's Name:

Date of Birth: Height: Weight:

Please give full details of circumstances of injury/onset of sickness:

Final diagnosis:

Date of Onset of Sickness / Date of Injury:

When did the patient first receive medical attention for this condition?

Was the disability sports related? Yes ☐ No ☐

If YES, please provide details:

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

If YES, please provide details:

Has the patient ever suffered with this or any similar condition before the present episode? Yes ☐ No ☐

If YES, please give details including dates treatment and consultation:

Are you the patient's usual doctor? Yes ☐ No ☐

If NO, please give name and address of claimant's usual doctor?

When did the patient first consult you for this condition?

How long have you been treating the patient?

On which date did incapacity commence? Date:

Is patient still incapacitated? Yes ☐ No ☐

If YES, please estimate when you expect the patient to be able to return to full time work or part time work?

Date:

Please advise on:

Working hours: Capacity:

Restrictions:

If NO, when did incapacity cease?

Date:

Was the patient hospitalised as a result of this condition? Yes ☐ No ☐

How many days was the patient hospitalised?

Days: From to

Detail any Surgical Procedures performed or planned:

Detail any Treatment recommended i.e. physiotherapy:

Is the condition due to Injury or Sickness arising out of the patient's employment? Yes ☐ No ☐

Doctor's Signature

Signed:

Date:

Qualifications:

Please use validation stamp or complete in block capitals:

Name:

Address:

Telephone No. Fax No:

Email Address:

Validation Stamp:

Other Disclosures

Personal information may be disclosed to:

- Brokers and agents who refer your business to us, your superannuation fund and any organisations appointed by them to administer your insurance related matter;
- Any person acting on your behalf, including your financial adviser, solicitor or accountant, executor, administrator, trustee, guardian or attorney;
- Your employer;

- Medical practitioners (to verify or clarify, if necessary, any health information you may provide), claims investigations and reinsurers (so that any claim you make can be accessed and managed). Other insurers to which your insurance is transferred by your employer or superannuation fund;
- Organisations, including overseas organisations, to whom we outsource certain functions.

In all circumstances where our contractors, agents and outsourced service providers become aware of personal information, confidentiality arrangements apply. Personal information may only be used by our agents, contractors and outsourced service providers for our purposes.

We may be allowed or obliged to disclose information by law, eg. Under Court Orders or Statutory Notices, pursuant to taxation or social security laws.