DUAL Personal Accident and Sickness Claim Form

The issue of this form is not an admission of liability

Please Ensure:

- *You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim.*
- *If any question is not applicable please state 'N/A'*
- *You have enclosed all requested information/documentation.*
- *You have signed this claim form.*
- *Your attending doctor fully completes the statement.*
- *ALL MEDICAL CERTIFICATES MUST STATE THE REASON FOR YOUR DISABLEMENT (e.g. "medical condition cannot be accepted)*

Section 1 – To be completed by Claimant

Certificate/Policy No:	
Full name of insured:	
Full name of claimant:	**Claimant date of birth:**
Occupation/Trade or Profession:	**Duties undertaken:**
Are you registered for GST? YES/NO **If YES, what is your ABN?**	
Are you entitled to claim any Input Tax Credits? YES/NO **If YES, please state %**	
Full address of claimant:	
Employers name:	
Contact details: Telephone Business: **Mobile**	**Telephone Home:** **Email:**

Section 2 – To be completed by Claimant

CLAIMS FOR INJURY / ILLNESS / DEATH

Please state fully:-

What is the injury or illness?	
If an injury, how exactly did it occur	
If an injury did it occur during working hours YES/NO	
Where did the injury occur or sickness manifest itself? **(ie Country/City)**	
When did the injury occur, or the illness begin; **or** **first manifest itself or when was it first diagnosed?**	**Date / /**
Did the injury or illness cause you to stop work? YES/NO	**If YES, when / /**
Have you returned to work full-time? YES/NO	**If YES, when / /**
Have you returned to work part-time? **YES/NO**	**If YES, what hours are you working** **Number of Days: Hours Worked:**
Please provide details of your usual duties:	
Details of your usual family doctor	**Doctors Name:** **Address:** **Telephone Number:**
When did you first get treatment from a medical practitioner for this condition? **Provide date: / /**	**Doctors Name:** **Address:** **Telephone Number:**

During the 24 hours before the injury, did you drink any alcohol or take any drugs?

YES/NO

If YES, state types and quantities:

Are you affected by any long term or chronic disability? YES/NO

If YES, please provide details

OTHER INSURANCE/BENEFITS

Are you claiming insurance or compensation from any other insurance company? eg Workers Compensation, Traffic Accident Commission, sports body or any income replacement. YES/NO

If YES, please provide further details

Name of organisation:

Name of insurer and contact telephone number:

Type of cover:

Amount claimed:

PRIVACY STATEMENT

DUAL Australia are committed to protecting your privacy. We use the personal information you provide to us in connection with your claim only for the purpose of assessing and managing the claim. We may need to provide that information to our underwriters and those we appoint to assist us with the claim. We will not trade, rent or sell your information. If you do not provide us with complete information, we cannot properly assess your claim. You can check the personal information we hold about you at any time. If you provide us with personal information about anyone else, we rely on you to have told them that you will provide their information to us, to whom we may provide it, the purposes for which we will use it and that they can access it. If the information is sensitive, we rely on you to have obtained their consent on these matters. For more information about our Privacy Policy, please refer to: www.dualaustralia.com.au

DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS

I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.

I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim I representatives any and all information with respect to any sickness or injury, medical history, consultation, prescri treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be consider effective as the original.

Your Signature:

Date: / /

Please Print Your Name

CLAIM LODGEMENT DETAILS

PLEASE FORWARD CLAIM DETAILS USING ONE OF THE FOLLOWING LODGEMENT PROCESSES

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

Online Lodgement (preferred):	**Or by Postal Address:**
1. http://figapp.csc.com.au/proclaim/ 2. Login: dualah 3. Password: claims (Please attach the completed claim form during the online lodgement and record the claim number)	Proclaim Pty Ltd Locked Bag 32012 Collins Street East Victoria 8003
Email Address: ahclaims@proclaim.com.au	**Fax No:** 1300 858 329

Phone Number:

Once the claim form has been completed, sent, and received by Proclaim, claim inquiries can be made to Proclaim on:

+61 (2) 92871319

Policy and coverage queries should first be directed to your Insurance Broker.

PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.
Please complete the following:

Bank: ____

SWIFT CODE (FOR NON AUSTRALIAN BANK):______________________________

Account Name(s): ____

BSB Number: ____

Account Number: ____

EMPLOYER OR PRINCIPAL CONTRACTOR STATEMENT

Claimant name					
First day not at work					
Date of employment with the company					
Gross weekly base rate of pay (averaged over the last 12 months prior to the date of disablement)					
Is there a workers' compensation claim lodged or to be lodged?					
If yes, what is the weekly compensation					
(Please attach all WorkCover correspondence)					
What payments have been made during the period of disablement					
WorkCover	**$**	**From / /**	**To / /**		
Normal pay	**$**	**From / /**	**To / /**		
What is the usual occupation of the claimant?					
Has the claimant returned to work? If yes, on what date:					
Name of company					
Contact details	**Address**				
Suburb		**State**		**Postcode**	
Telephone Number		**Email**			
Signature					
Name					
Position					

THIS SECTION MUST BE FULLY COMPLETED BY ATTENDING DOCTOR - ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON

Section 3. – Doctors STATEMENT

Patients name:	**Date of birth:**
Height:	**Weight:**
Please give full details of injury/illness	
Final diagnosis:	
When did the patient first receive medical attention for this condition?	
Has the patient ever suffered with this or any similar condition before the present episode? YES/NO **If YES, please give details including dates of treatment and consultation:**	
Are you the patient's usual doctor? **YES/NO**	**If NO, please give name and address of claimant's usual doctor:**
On what date did incapacity commence?	
Is the patient still incapacitated? YES/NO	**If YES, when will the patient be able to return to work?** **Date: / /** **If NO, when did incapacity cease?**
Was the patient hospitalised as a result of this condition? YES/NO	**If YES, how many days was the patient hospitalised?**
Is the condition due to injury or sickness arising out of the patient's employment? YES/NO	
Signed:	**Date:**
Qualifications:	
Please use validation stamp or complete in block capitals:	
Name:	
Address:	
Telephone Number:	**Validation stamp:**