Group Journey Injury Insurance

ZURICH

Claim form

All relevant sections are to be answered in full. Please print your answers.
Zurich does not admit liability by the issue of this form.

It is issued to enable the insured to lodge a written statement of claim.

Claim No. (Office use only)

Type of insurance cover

Branch
Policy No.
Due date
Broker/Agent
Address

Brokers please note: You can monitor the progress of a claim via Zurich Claims Online 24 Hours a Day, 7 days a week.

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any Personal or Sensitive Information ('Information'), you should know that:

We collect, use, process and store Personal Information and, in some cases, Sensitive Information about you such as health information, in order to comply with our legal obligations, assess your application and, if your application is successful, to administer the products or services provided to you, to enhance customer service and product options and manage a claim ('purposes').

If you do not agree to provide us with the Information, we may not be able to process your application, administer your policy or assess your claims.

By providing us or your intermediary with your Information, you consent to our use of this Information and where relevant for the purposes, you consent to our disclosure of your Personal Information, including your Sensitive Information, to your intermediary, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our business partners, medical and health practitioners, government offices and agencies, regulators, law enforcement bodies, your employer, Workcover authorities and as required by law within Australia or overseas.

Zurich may obtain Information from government offices, the parties listed above and third parties to administer policies and assess a claim in the event of loss or damage.

In most cases, on request, we will give you access to personal information held about you. In some circumstances, we may charge a fee for giving this access, which will vary but will be based on the costs to locate the information and the form of access required.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your Information to, a list of countries in which recipients of your Information are likely to be located, details of how you can access or correct the Information we hold about you or make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 132 687 or email us at Privacy.Officer@zurich.com.au

1 Insured details

Insured employer

Claimant's name

Address

Occupation Date of birth / /

Telephone (private) Telephone (work)

Telephone (mobile) Email (important)

What are your Gross Weekly Earnings $

For whom are you claiming? Self ◯ Spouse/Partner ◯ Child ◯ Give name

For what are you claiming? Total Permanent Disability ◯ Temporary Partial Disablement ◯ Death ◯

GST Tax Status – Registered Yes ◯ No ◯ ABN Taxable %

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2 Claims for Injury

What is the injury?

How exactly did it occur?

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

Did the injury cause you to stop work? Yes ◯ No ◯ If 'Yes', state when / /

Have you returned to work full time? Yes ◯ No ◯ If 'Yes', state when / /

Have you returned to work part-time? Yes ◯ No ◯ If 'Yes', state when / /

If 'Yes', what duties and hours are you working? Days Hours

Is this condition due to injury arising out of your employment? Yes ◯ – give details No ◯

Who is your usual doctor?

Name

Address

Telephone number

Have you received treatment from a medical practitioner for this condition? Yes ◯ – give details No ◯

Doctor's name

Address

Telephone number

When did you first see the medical practitioner?

Have you consulted any other medical practitioner for this condition? Yes ◯ – give details No ◯

Doctor's name

Address

Telephone number

Period

Did you go to hospital? Yes ◯ – give details No ◯

Hospital name

Address

Date of admission / / Date of discharge / /

Number of days in hospital

2 Claims for Injury

During the 24 hours before the injury, did you drink any alcohol or take any drugs? Yes ◯ – give details No ◯

State types and quantities

.....

.....

Have you ever had this or a similar condition in the past? Yes ◯ – give details No ◯

Treatment received

.....

Treatment start / / Treatment completed / / No of days

.....

Doctor's name Phone number

.....

Address

.....

What other significant medical or surgical treatment have you had in the past 5 years? Yes ◯ – give details No ◯

Treatment received

.....

.....

.....

Treatment start / / Treatment completed / / No of days

.....

Doctor's name Phone number

.....

Address

.....

Are you affected by any other long term or chronic disability? Yes ◯ – give details No ◯

.....

.....

3 Claims for additional benefits for injury

Not all policies provide these benefits. Please only complete if applicable.

1. Independent financial advice
2. Unexpired membership benefit
3. Chauffeur benefit
4. Tuition expenses

Give details, specifying each item

Item	Amount
	$
	$
	$
	$
	$
	$
	$
	$

Please attach invoices or other evidence of the expenses you have incurred.

3 Claims for additional benefits for injury (continued)

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 ◯ – give details No ◯

Name of insured organisation/employer and telephone number

Name of insurer and telephone number

Type of cover

Amount claimed per week $

4 To be completed by your employer

If Self Employed please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earning.

Name of your employer

This is to certify that of

has been unable to attend his/her occupation as a result of injury from / / to / /

His/her average Gross Weekly Salary at the time of this injury was $ per week

He/she has been employed since / /

His/her Sick Leave Entitlement at the time of this accident was days

Has a claim for Workers' Compensation been lodged? Yes ◯ No ◯

If 'Yes', what is the status of this claim? (If this claim has been declined, please provide evidence of the denial)

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission? Yes ◯ No ◯

Name of Employer or Supervisor (please print)

Telephone number

Signature of Employer or Supervisor Date

✗ / /

5 Medical practitioner's statement to company

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

Patients name

Usual occupation Date of birth / /

Height Weight

Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound)

Cause

If available provide a copy of X-ray report Is this condition – an injury ◯ or an illness ◯

Does the patient have any other injury or illness that is contribution to the condition? e.g. Osteoporosis Yes ◯ – provide details No ◯

Is condition due to injury arising out the patient's employment Yes ◯ – provide details No ◯

Was the disability sports related? Yes ◯ – provide details No ◯

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 ◯ – provide details No ◯

Name of patients usual doctor/medical practice

How long have you been the patient's usual doctor/medical practice?

Has the patient been hospitalized? Yes ◯ No ◯ Date of admission / / Date of discharge / /

Name of hospital

Has the patient had surgery or is it anticipated? Yes ◯ – provide details No ◯

Date performed or anticipated / / Give name of hospital

Did you provide other medical services (including pathology) to the patient? Yes ◯ – provide details No ◯

Was the patient referred by you or to you? Yes ◯ – provide details No ◯

Doctors details

Is the patient still disabled? Yes ◯ No ◯ If 'Yes,

Totally disabled (unable to perform any part of their occupation) / / to / /

Partially disabled (able to perform part of their occupation) / / to / /

If partially disabled, what duties could the patient perform and for how many hours a week?

Hours

5 Medical practitioner's statement to company (continued)

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers' Compensation insurer, Social Security, sports body or any other insurance body? Yes ◯ – give details No ◯

Name of company Claim number

Contact name Telephone number

Name of medical practitioner (please print)

Address

Telephone number

Signature of Medical practitioner Date

✗ / /

6 Declaration

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever this will affect my claim and my claim may be declined.

Signature of insured Date

✗ / /

7 Electronic funds transfer details

Following our approval of your claim, should you wish to have your settlement transferred directly into your bank account, (no credit card accounts can be edited) please provide the following details.

Name of financial Institution

Account name

BSB (Branch number) | | | | – | | | | Account number | | | | | | | | | | |

8 Medical release authority

Dear Doctor

I authorise you to release details of my personal medical history to Zurich Australian Insurance Limited or any of its authorised agents. A photocopy (or similar) of this authorisation is as valid as the original.

Name of insured Date of birth / /

Signature of insured Date

✗ / /

9 Membership confirmation

Membership number

Membership officer name

Membership officer signature Date

✗ / /

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