Claim form

Golf – Personal Accident

ZURICH

The company does not admit liability by the issue of the form. It is issued to enable the insured to lodge a written statement of claim.

CASE/CLAIM NUMBER

Important information

In the event of a Claim, Zurich Australian Insurance Ltd will:

- Within 10 business days of receipt of your claim we will notify your broker (or you) of our decision as to whether the claim has been accepted or not or, advise you if we require additional information and/or if we have appointed a loss assessor/Investigator.
- For claims where additional information is required we will make a decision within 20 business days, dependant upon the time required for you (or other independent parties) to respond to a request for additional information. If we are reasonably satisfied that all the relevant information pertaining to the claim has been made available, we will then decide to accept or deny the claim and notify you of our decision within the above timeframe.
- In some cases, due to unusual circumstances or the complexity of a claim (such as liability claims), these timeframes may not be practical and we will agree an alternate timeframe with your broker or you to make a decision on your claim. If we cannot reach an agreement, you are able to access our complaints handling procedures.
- Please be aware that in accordance with the General Insurance Code of Practice, these standards will not apply if any person who may be entitled to benefits under the policy has commenced proceedings in any court, tribunal or any other dispute handling process (other than the Insurance Ombudsman Service) in respect of this claim.

Privacy

- We need personal information about you to assess your claim. We will, where relevant, disclose your personal information (other than sensitive information such as health information) to your adviser (and any licensee or broker he or she represents), to our service providers (including loss adjusters and investigators), other insurers, insurance reference bureaus and our business partners for this purpose;
- Where relevant, to assess your claim we will also disclose personal information, including sensitive information about you such as health information, to medical practitioners, other health professionals, other insurers and reinsurers, legal representatives, and other consultants. By signing this Claim Form, you consent to those organisations and other professionals collecting, and us disclosing sensitive information about you for this purpose;
- In some cases, assessment and settlement of the claim is undertaken in conjunction with our insured. For example, we may act as an agent for our insured or the cost of claims may be shared between us and our Insured. In these cases, your personal and/or sensitive information will be shared between us and our insured (or their representatives) for the purpose of managing the claim;
- A list of the type of service providers, business partners and consultants we commonly use is available on request, or on our website - go to www.zurich.com.au and click on the Privacy link on our home page;
- If you do not provide the requested information or consent to its collection and disclosure as described above, the assessment of your claim may be delayed or we may not accept the claim;
- We may also disclose personal information about you where we are required or permitted to do so by law;
- In most cases, on request, we will give you access to the personal information we hold about you;
- If you would like to find out more, you can contact us by telephone on 132 687, e-mail us at Privacy.Officer@zurich.com.au or write to 'The Privacy Officer' at Zurich Financial Services Australia Limited, PO Box 677, North Sydney, 2059. Please provide details of your policy number/s and/or claim number where known.

Claimant details

Surname Given name(s) Date of birth / /

Postal address State Postcode

Phone number – Private Business

Mobile Fax

Your height Your weight

Please indicate (tick (✔) the box) which of the following best describes your present occupation.

(a) Clerical Work only ☐ (b) Performing Manual Work ☐ (c) Supervising Manual Work ☐ (d) Combination of (b) & (c) ☐

Are you self employed? Yes ☐ No ☐ If 'No', please provide the name & address of your employer

Name

Address State Postcode

If 'Yes', (i.e. you are self employed), please provide the details of your business

Name ABN ☐☐ ☐☐☐ ☐☐☐ ☐☐☐

Address State Postcode

ZU07496 - 6/06 - JMOY-6PV9AL-2006

Details of the policy

Name of your Golf club

ABN ☐☐ ☐☐☐ ☐☐☐ ☐☐☐ Policy number Renewal date / /

Details of the event

Date of accident / / Time of incident am/pm

Golf course (name and address) where accident happened

Name

Postal address State Postcode

Describe what happened in detail

Name of the person who caused the event (if relevant)

Address of person who caused the event State Postcode

Phone number of person who caused the event

Name of witness

Address of witness State Postcode

Phone number of witness

Details of the event

Please tell us what you are claiming for (see A to G) below.

Depending upon your injury, you will need to provide us with evidence of the injury as follows:

A. If you are claiming for dental benefits, you must provide us with a statement from a registered dentist on his/her letterhead confirming:
   - The type of treatment given
   - The number of teeth involved
   - The injury was as a result of the accident which occurred on the golf course

B. If you are claiming for broken or fractured bones or the amputation of an arm, foot, hand, leg, finger, toe or eye, you must provide us with a statement from a registered medical practitioner on his/her letterhead confirming:
   - The nature of the injury and treatment given
   - In the case of fractures, the statements needs to disclose if the fractures were compound (open) or simple (closed) fractures.
   - That the injury was as a result of the accident which occurred on the golf course

C. If you are claiming for emergency transport benefits, you will need to provide us with a statement from the party who provided the transport, outlining the following:
   - The service provided and the cost
   - That the transport was emergency in nature and provided immediately following the accident which occurred on the golf course

D. If you are claiming for internal injuries, you must provide us with a statement from a registered medical practitioner on his/her letterhead confirming:
   - The internal injuries suffered and treatment given
   - That the injury was as a result of the accident which occurred on the golf course

E. If you are claiming for the suture of a wound, you must provide us with a statement from a registered medical practitioner on his/her letterhead confirming:
   - Where the wound was and the number of sutures
   - That the wound was as a result of the accident which occurred on the golf course

F. If the claim is for accidental death, the legal representatives will need to:
   - Provide written evidence of their right to represent the deceased person
   - Provide a copy of the death certificate and evidence that the death occurred as a result of the accident which occurred on the golf course

G. If claiming for temporary total disability benefits, you will need to:
   - Provide evidence of earnings
     - If you are an employee this means your average pre-tax weekly rate of pay over the past 12 months (or over such period as you have been employed over the past 12 months), prior to your accident, excluding bonuses, commission overtime & any allowances
     - If you are self employed, this means your average pre-tax weekly income over the past 12 months prior to your accident (or over such period as you have been self employed in this business) derived from your personal exertion after deducting necessarily incurred in deriving that income
   - Have a registered medical practitioner complete the attached certificate

Medical statement – Temporary total disablement

To be furnished by the person claiming at his own expense

Name of Claimant (Patient)

Address State Postcode

Occupation

Date accident happened and where / /

How caused

On what date did you first attend the Claimant in consequence of present injury? / /

(If the injuries sustained to a hand or an arm, a foot or a leg, state whether it is the Right or Left).

Have you reason to suspect Claimant was not sober at the time of accident? Yes ☐ No ☐ If 'Yes', please give details

How long have you known the Insured?

Are you the Claimant's regular Medical Attendant? Yes ☐ No ☐ If 'No', who is the regular medical attendant?

To your knowledge, was the Insured at the time of the accident suffering from any disease or physical infirmity? Yes ☐ No ☐
If 'Yes', please provide details

Give date of last visit by the Claimant / /

Is the Claimant's incapacity due solely and directly to the accident stated, independently of any other cause? Yes ☐ No ☐
If 'Yes', please provide details

Note:
Temporary total disablement, for the purpose of this claim means that as a result of an accident one or more of the following conditions applies:

- the patient is for the time being wholly prevented from engaging (for reward or otherwise) in their own occupation or from attending school/college/university.
- the patient is for the time being unable to carry out all their domestic duties and have been required to employ domestic assistance to carry out these household duties.
- the patient is for the time being unable to perform at least two of the five following "Activities of Daily Living"
  - bathing and showering;
  - dressing and undressing;
  - eating and drinking;
  - using a toilet to maintain personal hygiene; and
  - moving from place to place by walking, either with or without the use of a walking aid.

I Estimate the Claimant will be **Temporally, Totally** disabled (as per the attached definitions) for:

weeks days

Commencing / /

I HEREBY CERTIFY that the foregoing statements are to the best of my knowledge, information and belief, true and complete, and that I am firmly of the opinion that the stated periods of the patient's Total and/or Partial Disablement are due solely and directly to the cause or causes I have stated.

Name (Please Print)

Address State Postcode

Qualification

Signature ✗ Date / /

Your 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 shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, the Policy shall be void and all rights to recover thereunder in respect of past or future injuries shall be forfeited.

I further agree that any professional person, Medical Practitioner, Dentist or Hospital Authority who has been or may hereafter be consulted by me relative to the injury is hereby authorised and directed to divulge at any time to Zurich Australian Insurance Limited, their legal representatives or Loss Adjusters, any information or history they may acquire with regard to any injury.

Signature	Date
✗	/ /

Golf Club Membership Verification (To be completed by Golf Club's Secretary/Manager, if this is a Club Policy

I am the Secretary/Manager of the club named in this claim and I verify that the above named person was a member of this club

Membership number at the time of event which lead to this claim. Furthermore I believe this to be a genuine claim.

Your name

Position

Signature	Date
✗	/ /

Please return this claim form to:

Zurich Australian Insurance Limited
PO Box 232E
Melbourne VIC 3001