DUAL
AUSTRALIA

Personal Accident and Sickness Insurance

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.**
- **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 THE CLAIMANT

Certificate/Policy No:			
Full Name of Insured Person:			
Date of Birth:			
Full Address:			
Suburb:		**Postcode:**	
Mobile:		**Email:**	
Employers Name:			
Occupation:			
Telephone Business Hours:			
Telephone Home:			

SECTION 2 – TO BE COMPLETED BY THE CLAIMANT

CLAIMS FOR INJURY / ILLNESS / DEATH

Please state fully:-

What is the injury or illness?				
If injured, how exactly did it occur?				
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?				
No:	**Yes:**	**If so when:**	**Date:**	
Are you a part time or casual employee?				
No:	**Yes:**			
Have you returned to work full-time?				
No:	**Yes:**	**If so when:**	**Date:**	

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Have you returned to work part-time?				
No:	**Yes:**	**If so when:**	**Date:**	/ /
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?				
No:	**Yes:**	**If so – when?**	/ /	
Who is your usual 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?				
If yes:	**When:**	/ / **to** / /		
At which Hospital?				
Detail surgery performed:				
During the 24 hours before the injury, did you drink any alcohol or take any drugs?				
No:	**Yes:**			
State Types and Quantities:				
Have you ever suffered this injury/illness or a similar condition before?		**No**	**Yes**	
Give details:				
Are you affected by any long term or chronic disability?		**No**	**Yes**	
Give details:				
OTHER INSURANCE / BENEFITS:				
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?				
No:	**Yes:**			
Give Details:				
Name of organisation/Insurer:				
Name of Insurer & Contact Details:				
Type of Cover:				
Claim Number:				
Amount Claimed:				
Attach a copy of the claim acceptance letter, Benefit Statement, other correspondence.				

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 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 me to furnish to Dual and the claims manager of Proclaim Pty Ltd, 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 Proclaim all information with respect to this Sickness or Injury to enable assessment of my claim.
I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Your Signature:	
Name – Print:	
Date:	/ /

PAYEES BANK DETAILS

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

Bank:	
Account Name(s):	
B S B Number:	
Account Number:	

SECTION 3 – 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?			**No**	**Yes**	
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?		**No:**		**Yes:**	
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?					
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 4 – DOCTOR'S STATEMENT

Patients Name:					
Date of Birth	/ /	**Height:**		**Weight:**	
Please give full details of circumstances of injury/onset of illness:					
Final diagnosis:					
Date of Onset of Sickness/Date of Injury:	/ /				
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?					
No:	**Yes:**				
If YES, please give details including dates treatment and consultation:					
Are you the patient's usual doctor?		**No**		**Yes**	
If NO, please give name and address of claimant's usual doctor?					
On which date did incapacity commence?	/ /				
Is patient still incapacitated?	**No:**	**Yes:**			
If YES please estimate when you expect the patient to be able to return to work?					
Date:	/ /				
If NO when did incapacity cease?	**Date:**	/ /			
Was the patient hospitalised as a result of this condition?		**No**		**Yes**	
How many days was the patient hospitalised?					
_____ **Days**	/ / **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?		**No**		**Yes**	
Signed:					
Date:					
Qualifications:					
Please use validation stamp or complete in block capitals:					
Name:					
Address:					
Telephone No.					
Validation Stamp:					

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) 92871322 Policy and coverage queries should first be directed to your Insurance Broker.	

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

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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.

Your acknowledgment and consent

Your signature below indicates your consent to such use and disclosures of your personal information as are indicated above.

Signature	**Name**