Claims X BIRST

Accident & Sickness

Claim form

Birst Discretionary Trust Arrangement.
If you need assistance with filling out this form, contact us on 1300 375 723 or claims.aus@claimsx.com.au

Important information

The issue of this claim form does not indicate acceptance of the claim. To assist us in assessing your claim, please:

1. Fully complete this form and supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents may result in a delay in assessing your claim.
2. Provide a comprehensive description of the circumstances of the loss, completing all relevant sections.
3. Provide additional supplementary information on a separate page if there is not enough space on this claim form.
4. Forward the completed claim form to Claims X at claims.aus@claimsx.com.au.

Member details

Member name:		
Daytime phone number:		
Email:		
Postal address:		
State:		Postcode:
Date of birth:	Height:	Weight:
Usual occupation:		
Employer's name:		
Employer's phone:		
Gross weekly salary/income (before tax):		

Banking details

Account name:	
BSB:	
Account number:	

Statement of claim (to be completed by the claimant)

When did the accident occur or when did you first become aware of your sickness or injury?

Date: Time:

What was the first day you were unable to attend work? Date:

What medical practitioner(s) did you consult?

Name: Date of visit:

Name: Date of visit:

Name and address of your **usual doctor** (family General Practitioner):

Full name:

Phone:

Address:

State: Postcode:

In your own words, please describe the injury or sickness:

Please describe exactly what you were doing at the time of your injury/sickness and how it happened:

Where did the injury or sickness occur?

Please state when you first became aware of the symptoms before consulting your GP or Specialist:

If your condition is a result of an accident, state whether the accident happened at work, in a road accident or whilst travelling to or from work or other:

Were the police in attendance as a result of this accident? Yes ☐ No ☐

Witness Name:

Witness Phone:

Witness Address:

Was hospitalisation required? Yes ☐ No ☐

Name of hospital:

Dates confined: From: To:

Have you ever suffered from this or a similar condition in the past? Yes ☐ No ☐
If **yes**, please give details and dates:

During the 24 hours before the injury, did you consume alcohol or drugs? Yes ☐ No ☐
If **yes**, please state type and what quantities:

Type: Quantity:

Are you making, or are you entitled to make a claim in respect of this injury or sickness for any of the following?
If **yes**, please provide details (and dates where applicable):

Benefit			Details
Sick Leave:	Yes ☐	No ☐	
Third Party Insurance	Yes ☐	No ☐	
Other Insurance	Yes ☐	No ☐	
Centrelink Benefits	Yes ☐	No ☐	
Workers' Compensation	Yes ☐	No ☐	
Other Government benefit	Yes ☐	No ☐	

When did you, or when do you expect to resume work? Date:

Please provide your reasons explaining why you are unable to carry out your usual duties:

Do you consider yourself fit for alternative duties? Yes ☐ No ☐
If **yes**, have you discussed the possibility with your employer and if so, what was the outcome?

Have you engaged in any other income earning employment since you became disabled? Yes ☐ No ☐
If **yes**, please provide details:

Have you ever made a previous claim in respect to Accident or Sickness Insurance?
If **yes**, please provide details:

Declaration

1. I, _____ solemnly and sincerely **DECLARE** that the information given by me in this claim is true and complete.
2. My Medicare number is: _____
3. I understand that the claim may be declined if the information supplied is untrue and I have not revealed all relevant facts.
4. I agree to supply any further information that may be requested of me in connection with my claim.
5. I authorise any Doctor, Dentist, Physiotherapist, Company, Firm or Person to disclose to Howden any and all information that they may request in connection with this claim.
6. I agree that a photocopy of this Authorisation shall be considered to be effective and valid as the original.
7. I have read and accept the Privacy Collection Statement provided with this claim form.
8. I hereby acknowledge and agree to the information contained herein (including personal information) being shared with the other members of our Discretionary Trust (Trust) as part of the Trust's Risk Management processes and reporting criteria with Birst, as it may be required to assist in the management of this claim and the administration of the Trust

Signature of Claimant:

Date:

Income details (skip if not applicable)

If self-employed

If the claimant is not an employee (i.e. a self-employed contractor) then the gross weekly income derived from personal exertion in their usual occupation, after deducting any expenses necessarily incurred in deriving that income, averaged over the number of weeks so engaged during the twelve (12) months immediately preceding the date of disablement giving rise to claim, **must be supplied.**

Your accountant's name:

Address:

Telephone no:

Please confirm employment/position status
(i.e. Director / Partner / Sole Trader / Other):

If employed as a wage earner, to be completed by your employer

I hereby certify that _____ has been unable to attend their usual occupation with the company as a result of an injury/injuries/sickness suffered on _____.

What was the employee's last day at work?

When is the employee expected to / did resume duties?

When did the claimant commence employment with this company?

Please describe the claimant's usual occupation listing details of primary responsibilities:

Has the employee lodged or intend lodging a Workers' Compensation claim? If **yes**, please provide a copy of confirmation of acceptance or rejection (letter) from the Insurer. Yes ☐ No ☐

Is there any additional information you would like to provide in relation to the submission of this claim?

Please see the attached **Declaration of pre-disability earnings** section of the claim form to be completed by you or your paymaster.

Name of company:

Postal address:

Signature of supervisor or paymaster: Dated:

Name of supervisor or paymaster (please print): Dated:

Email:

Phone:

Declaration of pre-disability earnings

Employee's name

Please provide a breakdown of the total earnings during the fifty-two (52) weeks prior to disablement, or for the period of employment if less than fifty-two weeks.

Prior to completing the following information, please read the definition of each of the Earnings Categories

All earnings listed should be before any deductions (i.e. income tax, etc), and should exclude superannuation.

Earnings Category	Definition	Total Earnings
Total Ordinary Earnings	*Ordinary Earnings are the gross wages of the employee excluding allowances, loadings, bonuses, and overtime.* *This amount should include all paid leave, such as sick leave, personal leave, annual leave, and rostered days off.*	$
Total Allowances	*Allowances can include, but are not limited to tool allowances, industry allowances, trade allowances, shift loadings, special rates, qualification based allowances (such as first aid, laser safety officer allowances, etc).*	$
Total Overtime	*Overtime refers to any and all overtime earnings regardless of the rate.*	$
Other Earnings	*If applicable, please specify the nature of Other Earnings included:*	$
Total Earnings	*Total of the above*	$
Total weeks wages included in above calculations		weeks

Employer Declaration

To avoid delays, please ensure that this form is fully completed with ALL "Ordinary Time Earnings" as detailed in definition above. Please note that Weekly Benefit entitlements will be calculated upon the information/declaration that you provide.
I sincerely declare that to the best of my knowledge the information provided above is true, accurate and complete.

Payroll officer's name:

Date:

Signature:

Doctor's statement

Important: please print legibly – this form cannot be accepted otherwise

1. The patient is responsible for any fee for this statement
2. This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist).
3. Dashes or blank spaces are not acceptable.
4. If the regular or usual doctor was not the treating doctor, this statement will also have to be completed by the claimant's regular doctor. If the claimant has been referred to another physician for treatment, a subsequent statement may be required to be completed by that physician.

1. Patient's full name:

2. How many years or months has the claimant been your patient/under your care?

a) What date were you first consulted by the claimant in connection with the present Sickness or Accident? Date:

b) How long had the patient been experiencing symptoms prior to consulting you for the first time?

c) Are these symptoms consistent with the current diagnosis?

d) When do you believe this condition manifested?

3. What is the exact nature of the present sickness or injury?

a) If X-Ray examination or other tests have been made, state finding and/or quote report.

4. What is the (proximate) cause of the disabling condition?

a) If X-Ray examination or other tests have been made, state finding and/or quote report. ☐ Yes ☐ No

b) Would you support a Workers' Compensation claim? If **no**, please explain why not ☐ Yes ☐ No

5. Has the patient previously suffered from the same or similar condition? ☐ Yes ☐ No

a) Dates of consultation:

b) Diagnosis

c) Was this occurrence/recurrence expected? If **yes**, why? ☐ Yes ☐ No

d) Do you expect any further recurrence of this condition? If **yes**, please provide details: ☐ Yes ☐ No

6. Is there anything in the patient's medical history that may have contributed or aggravated, either directly or indirectly to the Injury/Sickness? If yes, please provide details ☐ Yes ☐ No

7. Is there anything in the patient's medical history that may be likely to delay the recovery?
If yes, please provide details and advise how long recovery may be delayed ☐ Yes ☐ No

8. Please provide summary details of all past and present medical advice and treatment provided to the patient in respect of his/her current disablement.

9. Do you consider treatment other than that being received is essential to recovery?
If **yes**, please provide details. How might this promote a return to work? ☐ Yes ☐ No

10. Have you referred the patient to other specialist services or treatment?
If **yes**, please provide details and a telephone contact number: ☐ Yes ☐ No

11. If the claimant has already been hospitalised, please provide details below:

Name of hospital:

Dates:

12. Is treatment likely to be prolonged by any complications? If **yes**, please provide details and advise how long treatment may be prolonged ☐ Yes ☐ No

13. Has the claimant continued to follow medical advice? If **no**, please provide details ☐ Yes ☐ No

14. Is there any reason or evidence to suggest the patient was under the influence of intoxicants at the time of the accident or that intoxicants may have caused the injury? ☐ Yes ☐ No

15. When was the claimant obliged to cease work?

16. Return To Work

When did or when do you realistically expect the claimant to resume work?	Date
Full unrestricted duties	Date
Modified duties, if necessary	Date
Normal duties in reduced capacity (i.e . restricted hours)	Date
If unable to return to work in a partial capacity, please provide an explanation.	Date

17. I hereby certify that the patient has been and or will be totally disabled from carrying out his / her usual occupational duties as follows:

    From: To (inclusive):

18. Additional remarks (e.g. Prognoses, life expectancy, occupational rehabilitation, surgery waiting list):

Doctor's declaration

I hereby certify that I have personally examined the above-named claimant and that in my opinion the statements made in the Statement of Claim section of this Claim Form are consistent with the Claimant's injury or sickness.

I have read and accept the Privacy Collection Statement provided with this Claim Form.

Name:

Provider Number:

Qualifications:

Telephone:

Address:

Email Address:

Date:

Signature:

Collection Statement under the Privacy Act 1988 (Cth)

In accordance with the Privacy Act 1988 (and subsequent amendments), we Alternative Risk Management Services Pty Ltd ABN 70 649 963 191| AFSL 530893 and Claims X Pty Ltd ABN 57 649 962 701| AFSL 530894, as related companies to Howden Insurance Brokers (Australia) Pty Ltd ABN 79 644 885 389 | AFSL 539613 (Howden), draw your attention to the following:

- We may collect personal information or sensitive information about you.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other Claims X products or services. If you are applying for or renewing insurance or membership, or membership of an Alternative Risk Management Services Discretionary Trust Arrangement (DT Arrangement), the information is required pursuant to your duty of disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909, or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and Claims X related Group companies, such as Howden Insurance Brokers (Australia) Pty Ltd. Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore. Please read our Privacy Policy on Howden's website (https://www.howdengroup.com/au-en/privacy-policy) if you would like further information or contact our Privacy Officer on the contact details below:

  Post: Howden Insurance Brokers (Australia) Pty Ltd
  Level 23, 20 Bond Street
  Sydney, NSW 2000
  Email: privacy.pacific@howdengroup.com

- By providing this information, you agree to us collecting, using and disclosing your personal or sensitive information as outlined in this Privacy Collection Statement.
- If you do not provide all or part of the information requested, we may be unable to process your application, administer your claim or provide other required services, or your application for insurance or membership of a DT Arrangement may be declined or you may prejudice your insurance cover or cover under a DT Arrangement.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's prior consent.
- Our Privacy Policy can be made available on request or can be accessed on Howden's website https://www.howdengroup.com/au-en/privacy-policy.

For further information or to make a complaint regarding Claims X's Privacy Policy, contact your Broker, Claims Manager or the Privacy Officer for Howden and Claims X.