



ace insurance

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Australian Trainers' Association
Group Personal Accident Insurance Claim Form

- 1. Please complete the Policy and Claimant Details Sections and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully.
3. To avoid delays in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
4. Claims may be subject to an excess as described in your Policy.
5. Please send this form and all documentation to: The Accident & Health Claims Department, ACE Insurance Limited, GPO Box 4065, Sydney, NSW 2001.

A. POLICY AND CLAIMANT DETAILS (COMPLETE FOR ALL CLAIMS)

POLICY HOLDER: Australian Trainers' Association

Policy Number: 02P0014428 / 02P0014429 Expiry Date: / /

Your active level of cover is? [] Standard Cover (Bronze) [] Advanced Cover (Silver) [] Superior Cover (Gold)

Name of Broker who provided the cover: Jardine Lloyd Thompson Pty Ltd

Covered Person's Name, Home Address, Postal Address, Telephone No., Email, Employer's Name, Occupation/s, Date of Birth

What are your gross weekly earnings: \$

What Benefit are you claiming for?

- (A) Death/Capital Benefit Yes []
(B1) Routine Duties Benefit Yes []
(B2) Inability to carry out usual Income Earnings Occupation Benefit Yes []
(B3) Injury Resulting in Fractured Bones Benefit Yes []

NB

The Claimant can claim only one (1) of the items under Benefit (B).

Please attach invoices or other evidence of expenses you have incurred if the claim is for (B1).

B.**CLAIMS FOR INJURY / INCLUDING DEATH****What is the injury?**

If injured, how exactly did it occur?

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

/	/
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Did the injury cause you to stop work?No Yes if Yes, when?

/	/
---	---

Have you returned to work full-time?No Yes if Yes, when?

/	/
---	---

OR**Have you returned to work part-time?**No Yes if Yes, when?

/	/
---	---

– if Yes, what hours and duties are you currently working?

Days Hours

Duties

--

Who is your usual family doctor?

Name

--

Address

--

State

Postcode

Telephone Number

--

()

When did you first get treatment from a medical practitioner for this condition?

Doctor's Name

--

Address

--

State

Postcode

Telephone Number

--

()

When did you first see the medical practitioner?

/	/
---	---

Have you consulted another medical practitioner for this condition?No Yes – if Yes, give details

Doctor's Name

--

Address

--

State

Postcode

Telephone Number

--

()

Period

--

Were you hospitalized?No Yes – if Yes, give details

Hospital Name

--

Address

--

State

Postcode

Date of Admission & Discharge

--

Number of Days in Hospital

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During the 24 hours before the injury, did you drink any alcohol or take any drugs other than those prescribed to you by a doctor?No Yes – if Yes, give details

State types & quantities

--

Have you ever had this or a similar condition in the past?

No Yes – if Yes, give details

Date(s),

Treatment received

Name of treating Doctors/Specialists

Addresses of Doctors/Specialists

who treated you

State	Postcode

C. 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.

No Yes – if Yes, give details

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Name of insured organization/employer & telephone number

Name of Insurer & Telephone No.

Type of cover

Amount claimed per week

\$ _____ per week

D. ELECTRONIC FUNDS TRANSFER DETAILS

Following ACE's approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

Name of Financial Institution:

Account Name:

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BSB Number:

Account Number:

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E. GST INFORMATION

(a) Are you registered for GST Purposes

Yes No

(b) What is your Australian Business Number (ABN)?

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(c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made?

Yes No

(d) If **YES**, what percentage of the GST did you claim or are you entitled to claim? (if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

%

F.**TO BE COMPLETED BY YOUR EMPLOYER WHERE THE CLAIM IS FOR ITEM (B2)**

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

Name of Employer

This is to certify that (Covered Person's Name)

of (address)

State	Postcode

has been unable to perform his/her occupation as a result of Injury from

/ /	to	/ /
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His/Her average Gross Weekly Salary at the time of this accident was

\$	per week
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He/She has been employed since

/ /

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

	days
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Has a claim for Worker's Compensation been lodged

Yes No

In the case of a motor vehicle accident, has a claim been lodged against the Traffic Accident Commission?

Yes No

Signature of Employer or Supervisor

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Name of Employer or Supervisor (please print)

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Telephone Number

()	Date / /
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G.**PRIVACY CONSENT - CLAIM ASSESSMENT**

Protection of My Privacy
 Acknowledgement and Consents

ACE Insurance Limited (ACE) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principles.

A copy of our Privacy Policy is available on our website at www.aceinsurance.com.au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by ACE or any third party that ACE provides the information to for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:

- Any information provided in relation to your claim;
- Any information that is health information or sensitive information, including, without limitation, your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
- Any other personal information that you may provide to ACE or its third party contractors;
- Any information relating to any insurance policy on your life, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- Any other information relating to your income, assets, liabilities and solvency; and
- Any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To process your claim ACE may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant retained by ACE, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

ACE may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ACE group, other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. ACE may also disclose your personal information to witnesses in respect to your claim.

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, ACE may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1800 815 675 or email customer.relations@ace-ina.com.

H.**MEDICAL AUTHORITY, DECLARATION AND POWER OF ATTORNEY**

I DECLARE THAT,

I understand that by investigating my claim or by accepting proofs of my claim, ACE has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to ACE using and disclosing my personal information pursuant to ACE's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to ACE's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to ACE such personal information (including health information) as ACE in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to ACE in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint ACE to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant

Date

 / /

Name of Claimant

Signature of Witness

Date

 / /

Name of Witness

Medical Practitioner's Statement to Company

THE POLICYHOLDER IS RESPONSIBLE FOR ANY FEE FOR THIS STATEMENT
THIS FORM SHOULD BE COMPLETED AND RETURNED TO ACE PROMPTLY

Patient's Full Name

Date of Birth

 / /

Height

cms

Weight

kgs

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

Cause:

If available please 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 contributing to the condition? eg: Osteoporosis

No Yes – give details

Is condition due to injury or sickness arising out of the patient's employment?

No Yes – give details

Was the disability, sports related?

No Yes – give details

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?

No Yes – give details

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

yrs

Has the patient been hospitalised

Date of Admission

Date of Discharge

Name of Hospital

Name of patient's usual doctor/medical practice

Has the patient had surgery or is it anticipated?

No Yes – give details

Date performed or anticipated

 / /

Give name of hospital?

Did you provide other medical services (including pathology) to the patient?

No Yes – itemise, give details

Date	/	/	
Date	/	/	

Was the patient referred by you or to you?

No

Yes – give details

Please provide name and address of referring doctor

Name

Address

Date of referral

/ /

Is the patient still disabled?

No – when did the patient return to work?

/ /

Yes – how long will the patient be:

- totally disabled (unable to perform any part of their occupation)

from

/ /

to

/ /

- partially disabled (able to perform part of their occupation)

from

/ /

to

/ /

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

Hours per week

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?

No

Yes – give details

Name of Company and Claim No.

Contact Name and Telephone No.

Remarks

Signature of medical practitioner

Name – print

Qualifications

Address

Telephone Number

Date

/ /