Group Personal Accident & Sickness Claim Form

Instructions

1. Please read and complete this claim form carefully.
2. Answer all questions in full and attach any pages of additional information to ensure we can process your claim promptly.
3. Please send your completed claim form and attachments to:

Email:
ah.claims@allianz.com.au

OR

Allianz Australia Insurance Limited
Attention: A & H Claims
GPO Box 4049
Sydney NSW 2001

Please note:

- As each claim is unique, we may require further information to consider your claim.
- For any enquiries regarding your claim, please contact Allianz on 1300 803 063.
- The supply or acceptance of this form is not an admission of liability on the part of Allianz.
- You must arrange for your regular registered medical practitioner to complete the Medical Certificate, at your expense. If you are experiencing financial difficulty and cannot pay the fee for the Medical Certificate you should contact us to discuss your options.
- Please advise us if you believe you may require additional assistance with any part of the claims process, and we can discuss how best we can support you.

Your details

Full name _____ Date of birth ____ / ____ / ____

Address _____ State _____ Postcode _____

Telephone no. (___) _____ Email address _____

Preferred method of contact Email ☐ Telephone ☐ Letter ☐

Authorised person

Should you wish to authorise any other person to act on your behalf (which may include discussing your medical history), please complete an Accident & Health Third Party Authority form for each authorised person.

Policy details

Policy number AAH0958644

Policy owner Touch Football Australia Limited

Policy start date 30 / 06 / 2006

Payment details

Please provide details of the bank account we should use for payment of benefits approved to be paid to you.

Name of financial institution _____

Name of account holder _____

BSB number _____

Account number _____

Benefits claimed

Please review the Policy Wording and Schedule, and select the benefits you wish to claim.

Note that not all Policies provide these Benefits. Please only complete if applicable.

- ☐ **Lump Sum/Capital Benefits**
- ☐ **Bodily Injury ~~Resulting in Surgery outside Australia~~**
- ☐ ~~**Weekly Benefits - Injury**~~
- ☐ ~~**Sickness Resulting in Surgery outside of Australia**~~
- ☐ ~~**Weekly Benefits - Sickness**~~
- ☐ ~~**Fractured Bones - Lump sum benefits**~~
- ☐ ~~**Loss of Teeth or Dental Procedures - Lump sum benefits**~~

Sickness or injury details

Please provide specific details of the sickness or injury that is being claimed? _____

_____

Did the sickness/injury occur:

☐ at work; Touch Football

☐ travelling to/from work; or

☐ outside of work

If you are claiming for a sickness, please provide details of when symptoms first commenced.

Date _____ / _____ / _____

What were the symptoms you first experienced? _____

If you are claiming for an injury, please provide details of when and how the injury occurred.

Date of injury? _____ / _____ / _____ Time _____

Where did the injury occur? _____

How did the injury occur? _____

_____

Please provide details of any witnesses to the injury (if there are additional witnesses, please attach a separate page with the information)

Name of witness _____

Address _____ State _____ Postcode_____

Telephone no. (___) _____ Email address _____

Did the injury or sickness cause you to stop work? Yes ☐ No ☐ If "Yes", from when? _____ / _____ / _____

Have you returned to work full-time? Yes ☐ No ☐ If "Yes", when? _____ / _____ / _____

Have you returned to work part-time work or restricted/modified duties? Yes ☐ No ☐ If "Yes", when? _____ / _____ / _____

What hours and duties are you working per week? Days _____ Hours _____

Full duties ☐ Modified or restricted duties ☐ If you are working modified or restricted duties, please provide details_____

_____

_____

_____

Sickness or injury details continued...

Have you undergone rehabilitation or a return-to-work program? Yes ☐ No ☐ If "Yes", please provide details or attach your return to work plan

Have you received medical advice that your condition is permanent and/or unlikely to improve? Yes ☐ No ☐

If "Yes", please provide details of the medical practitioner who provided this advice

Name of medical practitioner _____

On what date was this advice provided to you? _____ / _____ / _____

Have you previously had the same or a similar condition? Yes ☐ No ☐ If "Yes", please provide details below.

Date _____ / _____ / _____ Details (include any doctors seen) _____

Please attach any Medical Certificates, Discharge summaries or reports that are in your possession for this condition.

Diagnosis and treatment details

When did you first obtain medical advice or treatment for this condition? _____ / _____ / _____

Name of current treating doctor/medical centre treating you for the condition you are claiming

Name of medical practitioner (or hospital) _____

Address _____ State _____ Postcode_____

Telephone no. (___) _____ Email address _____

Please provide details of any specialist seen in relation to the current medical condition

Name of specialist _____

Address _____ State _____ Postcode_____

Telephone no. (___) _____ Email address _____

If there are additional medical practitioners, please attach a separate page with the information.

What treatment are you receiving for this condition? _____

Details of any hospitalisation for the conditions preventing you from working

1. Period of admission _____ / _____ / _____ to _____ / _____ / _____

   Name of hospital _____

   Address _____ State _____ Postcode_____

   Reason for admission _____

2. Period of admission _____ / _____ / _____ to _____ / _____ / _____

   Name of hospital _____

   Address _____ State _____ Postcode_____

   Reason for admission _____

If there are additional periods of hospitalisation, please attach a separate page with the information.

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Other insurance claims

Do you have any other insurance claims including workers compensation (either current or past) for the conditions preventing you from working? Yes ☐ No ☐

If "Yes", please provide details below

Workers compensation ☐ Income protection/life insurance ☐ Centrelink ☐

Motor Accident compensation ☐ Other benefits ☐

Name and contact details of insurer _____ Reference number _____

Status of claim _____ Benefits commenced ____ / ____ / ____

Name and contact details of insurer _____ Reference number _____

Status of claim _____ Benefits commenced ____ / ____ / ____

Privacy

At Allianz, we give priority to protecting the privacy of your personal information. We do this by handling personal information a responsible manner and in accordance with the Privacy Act 1988.

How we collect your personal information

We usually collect your personal information directly from you. We may also collect it from your agents, health service providers, other insurers, Centrelink, your employer, and other third parties involved in your claim. In some cases, we may also collect information from publicly available sources.

Why we collect your personal Information

We collect your personal and sensitive information for the purposes of claims management. This information will be used to assess and process this claim, compile and analyse data, and resolve claim disputes.

If you do not provide your personal information we require we may not be able to assess or process this claim.

Who we disclose your personal information to

We may disclose your personal information to others for the purpose outlined above. This may include disclosure to third parties who assist us in assessing and processing this claim, including other insurers, reinsurers, health service providers, investigators, our specialist advisors, our service providers, dispute resolution bodies or as required by law.

Disclosure overseas

Your personal information may be disclosed to and stored by service providers that may be located overseas. The countries in which these recipients may be located will vary from time to time.

Access to and correction of your personal information and complaints

You may ask for access to the personal information we hold about you and seek correction by contacting us. Our Privacy Policy contains details about how you may make a complaint about a breach of the privacy principles contained in the Privacy Act 1988 and how we deal with complaints. Our Privacy Policy is available at www.allianz.com.au or contact us on 1300 360 529 EST 9am - 5pm, Monday - Friday.

Declaration and authority

I understand and declare that: the information given in this form is truthful, accurate and complete; no information likely to affect this claim has been withheld;

I understand that this claim may be refused if information is untrue, inaccurate or omitted; and all personal information provided by me about another person is provided with their consent.

I authorise, consent to and direct all health providers, including but not limited to medical practitioners, practices, psychologists, dentists, allied health services providers or any hospitals, Medicare, my employer (and their representatives and agents), insurance brokers, the Police, the Coroner and all insurance companies to supply Allianz (or its agents) with any health information, employment, accident or insurance information which they hold, are aware of or able to obtain with regard to me.

I agree that my digital signature and a photocopy or photograph of this Authority when attached to a letter or email from Allianz (or its agents) shall be considered to be valid as if it were the original Authority personally signed by me.

PLEASE NOTE: IF THIS FORM IS ELECTRONICALLY SIGNED BELOW, IT WILL BE LOCKED AND NO FURTHER CHANGES WILL BE POSSIBLE. PLEASE CHECK INFORMATION ON ALL PAGES IS CORRECT AND COMPLETE BEFORE SIGNING. IF YOU SUBSEQUENTLY DISCOVER ANY OF YOUR ANSWERS ARE INCORRECT, PLEASE CALL US ON 1300 803 063

Print name _____ Date ____ / ____ / ____

Your signature _____