



# INSURANCE ADVISERNET AUSTRALIA PTY LIMITED

AUSTRALIAN FINANCIAL SERVICES LICENCE NUMBER: 240549  
ABN 81 072 343 643

*Proudly Australian Owned and Operated*

www.insuranceadviser.net

## Injury or Sickness Benefit Claim Form

The supply or acceptance of this form is not an admission of liability on the part of Allianz.

The following claim form has been partially completed with standard information you have already provided to Insurance Advisernet Australia Pty Limited. Please check this information to ensure it is correct and advise us of any changes, as well as completing all other information on the form.

**Claim Number** \_\_\_\_\_

**Branch Code:** \_\_\_\_\_ **Customer Code:** \_\_\_\_\_

**Name of Insured:** \_\_\_\_\_

Contact Person \_\_\_\_\_

Home Phone No. \_\_\_\_\_ Work Phone No. \_\_\_\_\_ Mobile No. \_\_\_\_\_

Email \_\_\_\_\_

Occupation \_\_\_\_\_

Postal Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Broker/Agent Name \_\_\_\_\_ Phone No. \_\_\_\_\_

Policy No. \_\_\_\_\_ Excess \$ \_\_\_\_\_

Inception Date \_\_\_\_\_ Expiry Date \_\_\_\_\_

### G.S.T

Are you registered for GST purposes? \_\_\_\_\_ A.B.N. \_\_\_\_\_

To what extent are you entitled to claim an Input Tax Credit on the GST for this policy? \_\_\_\_\_ %

### Claimant

Claimant's Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ Relationship to Insured \_\_\_\_\_

Postal Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Residential Address \_\_\_\_\_

\_\_\_\_\_ Postcode \_\_\_\_\_

Phone No. (Home) \_\_\_\_\_ Phone No. (Work) \_\_\_\_\_ Mobile No. \_\_\_\_\_

Occupation \_\_\_\_\_ Average Gross Weekly Earnings\$ \_\_\_\_\_  
(over last 12 months)

### Employment

Are you employed by someone else? Yes  No

If Yes, Name of Employer \_\_\_\_\_ Phone No. \_\_\_\_\_

Nature of Employment Full Time  Part Time  Temporary

Are you self-employed? Yes  No

If Yes, Trading/Business Name \_\_\_\_\_

Was your business fully operational and were you fully employed at the time of injury/sickness? Yes  No

Give Details \_\_\_\_\_

Give the extent and duration of your usual working hours? Extent \_\_\_\_\_ Days Duration \_\_\_\_\_ Hours

**Employment History**

Have you engaged in employment other than your normal occupation since this Policy was issued?

Yes  No

If Yes, give details \_\_\_\_\_

Have you been able, since the injury/sickness occurred, to attend to your usual occupation, profession or business(or any portion of it)?

Yes  No

Give details \_\_\_\_\_

**Medical History**

Have you in the past received medical advice or treatment in respect of the injury or illness now being claimed?

Yes  No

Give details \_\_\_\_\_

**DEFINITIONS \* Temporary Total Disablement**

*Disablement which entirely prevents you from engaging in your usual occupation, profession or business*

**\* Temporary Partial Disablement**

*Disablement which entirely prevents you from carrying out a substantial part of the duties undertaken by you in connection with your usual occupation, profession or business.*

**Disablement**

The Date disablement commenced (Date) \_\_\_\_\_

I have been totally disabled for \_\_\_\_\_ Days From \_\_\_\_\_ To \_\_\_\_\_

I have been partially disabled for \_\_\_\_\_ Days From \_\_\_\_\_ To \_\_\_\_\_

I am now Not Disabled  Totally Disabled  Partially Disabled

How much longer is the disability likely to continue? \_\_\_\_\_

**Other Insurance**

Are you Insured elsewhere for injury or sickness?

Yes  No

If Yes, name of each Insurer \_\_\_\_\_

Are you eligible for Workers' Compensation?

Yes  No

Have you claimed or are you claiming for Workers' Compensation benefits?

Yes  No

If Yes, who is your Insurer? \_\_\_\_\_

Date Claim lodged \_\_\_\_\_ Claim No. \_\_\_\_\_

**Injury**

Location where injury occurred \_\_\_\_\_

Particulars of Incident \_\_\_\_\_

Date/Time of injury \_\_\_\_\_

What were you doing at the time of the injury? \_\_\_\_\_

How did the injury occur? \_\_\_\_\_

Name and extent of injuries \_\_\_\_\_

Have you suffered from this type of injury before?

Yes  No

Give details \_\_\_\_\_

**Sickness**

Date the sickness was first contracted \_\_\_\_\_

Nature of sickness \_\_\_\_\_

How and where contracted? \_\_\_\_\_

Have you suffered from this sickness before?

Yes  No

Give details \_\_\_\_\_

**Treatment**

Name of medical attendant who attended this condition \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Name of your regular medical attendant \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

**Please attach any medical certificate(s) or report(s) that are in your possession for this Injury/Illness**

**MEDICAL AUTHORITY**

I authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the underwriter any information it requires of any sickness or injury to me or my physical or mental condition or prognosis, or my employment to assist in the proof and settlement of my claim. A photocopy or faxed copy of this authority can be acted upon as if it were an original.

Signature \_\_\_\_\_

Date \_\_\_\_\_

**Business Expenses:** Are you claiming for Business Expenses? Yes  No

Give details \_\_\_\_\_

Nominated Expense	Date Incurred	Amount
		\$
		\$
		\$
		\$
		\$
		\$

**Please attach documentation to support Business Expenses.**

**PLEASE ARRANGE FOR THE MEDICAL CERTIFICATE SECTION OF THIS FORM TO BE COMPLETED BY THE DOCTOR WHO YOU CONSULTED FOR THIS INJURY OR SICKNESS**

Privacy: The Privacy Act 1988 requires us to tell you that as an insurer we collect your personal and sensitive information in order to calculate your loss and entitlements, determine our liability, compile data and handle claims. When handling claims, we may have to disclose your personal and other information to third parties such as other insurers, reinsurers, loss adjusters,

external claims data collectors, investigators and agents or other parties as required by law.

You have the right to seek access to your personal information and to correct it at any time. Please contact us on 1300 366 085 EST 9am-5pm, Monday-Friday and advise us of the changes.

IDR Statement: Disputes are not an everyday occurrence at Allianz. However we do provide an internal dispute resolution process should any dispute arise. Please feel free to ask for details.

If you are not satisfied with the outcome of this process, we will advise you how to contact the insurance industry's external independent complaints scheme (subject to eligibility).

Declaration: I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. I/We acknowledge that I/we have read and understood the Privacy Act 1988 information referred to above and

consent to the collection, storage, use and disclosure of personal and sensitive information of all persons affected by this claim, with their approval. I/We acknowledge that if I/we do not agree to the collection of this personal and sensitive information then Allianz will be unable to process my/our claim.

Signature of Insured \_\_\_\_\_

Date \_\_\_\_\_

**MEDICAL CERTIFICATE**

**At your own expense, you must have this certificate completed by a duly qualified Medical Practitioner, who is requested to return this Claim Form directly to us within 7 days.**

Name of Attending Physician (please print) \_\_\_\_\_

Qualifications \_\_\_\_\_

Address \_\_\_\_\_

Postcode \_\_\_\_\_

Name of Patient (please print) \_\_\_\_\_

**If you are unable to answer any of the questions below, please indicate.**

Describe Injury/Sickness \_\_\_\_\_

\_\_\_\_\_

When did you first treat the Patient for this condition? \_\_\_\_\_ Date \_\_\_\_\_

Has this patient been referred to you? If so, please provide name and contact details of the referring doctor.

\_\_\_\_\_

How long has this condition (in your opinion) been in existence? \_\_\_\_\_

Please provide all treatment dates for this condition \_\_\_\_\_

\_\_\_\_\_

**Present condition**

Prognosis \_\_\_\_\_

If hospitalised, give dates From \_\_\_\_\_ To \_\_\_\_\_

Name of Hospital \_\_\_\_\_

Describe any surgery \_\_\_\_\_

Have you any reason to suppose that the patient was under the influence of intoxicants at the time of the accident? Yes  No

Date patient was Totally Disabled \_\_\_\_\_

When did you release the patient to perform regular duties? \_\_\_\_\_ Date \_\_\_\_\_

When did you release the patient to perform light duties? \_\_\_\_\_ Date \_\_\_\_\_

In your opinion, probable further disability should not exceed Weeks \_\_\_\_\_ Months \_\_\_\_\_

**Medical History**

Has the patient previously suffered from the same or a similar injury or sickness? Yes  No

If Yes, Date \_\_\_\_\_ Diagnosis \_\_\_\_\_

Name of Physician who previously treated patient \_\_\_\_\_

Were there any complications? Yes  No

If Yes, give details \_\_\_\_\_

Are the patient's symptoms due or traceable exclusively to this previous Injury/Sickness? Yes  No

Is there anything in the patient's medical history which may have contributed, directly or indirectly, to the Injury/Sickness or which may be likely to retard the patient's recovery? Yes  No

Give details \_\_\_\_\_

\_\_\_\_\_

Signature of Attending Physician \_\_\_\_\_ Date \_\_\_\_\_



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## GST Information Declaration Form

Claim Number \_\_\_\_\_

1. Are you registered for GST Purposes? \_\_\_\_\_ (go to 6. below)
2. If Yes, what is your ABN? \_\_\_\_\_
3. Have you claimed an Input Tax Credit (ITC) on your insurance premium?
4. If Yes, what is the ITC claimed (as a percentage of GST payable)? \_\_\_\_\_ %
5. What ITC are you entitled to claim on the terms below (if there is insufficient space to cover all items, please attach a separate sheet with details)

Item	ITC%	Item	ITC%

6. I declare the above information is true.

Name (please print): \_\_\_\_\_

Signature: \_\_\_\_\_

Date: \_\_\_\_\_