Four Wheel Drive Victoria
Personal Accident Claim Form

EMAIL: CLAIMS@FULLERTONHEALTHCS.COM.AU
PHONE: +61 2 8256 1770
FAX: +61 2 8256 1775
LEVEL 10 33 YORK STREET
SYDNEY NSW 2000

INSTRUCTIONS

1. You fully complete Sections 1 - 5 of the claim form including either the illness or injury statement. We cannot proceed with the claim without this information
2. Ensure you sign the privacy declaration (Section 7)
3. **YOUR EMPLOYER** fully completes Section 8 of the claim form and includes 12 months payroll history.
4. **YOUR DOCTOR** fully completes the two page "Medical Practitioners Statement"
5. Attach a copy of your most recent Payslip to your claim submission.
6. Scan and email the claim form through to Four Wheel Drive Victoria Head Office: office@fwdvictoria.org.au

We cannot proceed with the claim without this information.

FAQ's:

How long will it take to complete my section of the form?

This should only take about 10 - 15 mins. We want to settle your claim for you as quickly as we can. If insufficient information is provided or if corrections are required this will likely lead to unwanted delays.

How can I check the progress of my claim?

Please contact Affinity Insurance Brokers on (03) 8587 7777 and advise that your query relates to a Personal Accident Claim for Four Wheel Drive Victoria

Please provide the claim number you received from the acknowledgment notification.

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CLAIM FORM

PERSONAL ACCIDENT &/OR SICKNESS

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
3. The issue of this form is not an admission of liability.
4. Once completed please either email or mail the claim form to Fullerton Health Corporate Services.

SECTION 1: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

Employer name

Policy Number

Title

Given Name(s)

Gender ☐ M ☐ F

Family Name

Date of Birth

Residential Address

Suburb

State

Postcode

Email Address (important)

Do you consent to us communicating with you by email? Y ☐ N ☐

Daytime Contact Number

Alternative Number

Occupation, Trade or Profession

Work Site / Location

For what are you claiming? ☐ Weekly Benefit ☐ Capital Benefit ☐ Death

SECTION 2: EFT AUTHORISATION

Please tick preferred method of Payment for refund.

I hereby authorise and request that Fullerton Health Corporate Services credit my bank account as indicated below:

☐ Direct/EFT Payment

Account Holders Name

BSB Number (6-Digits)

Account Number

Bank

☐ Cheque

Payee

SECTION 3: DETAILS OF INJURY - COMPLETE IF AS A RESULT OF ACCIDENT

Date of Accident | Time | AM / PM

Event/Address where accident occurred:

Were there any witnesses to the accident? ☐ Yes ☐ No

Witness Name:

Witness Address:

Please describe how the accident / injury occurred:

What were the injuries?

Have you previously been treated for any serious injury? ☐ Yes ☐ No

If Yes, please give details:

Give details of any previous claim made for any previous injury against any insurance company: (please attach separate sheet if insufficient)

During the 24 hours before the injury, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

If Yes, please state types & quantities:

SECTION 5: TREATMENT RECEIVED (1 of 2)

Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

Was hospital treatment required? ☐ Yes ☐ No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

When did you stop work? ☐☐☐☐☐☐☐☐ Time ☐☐☐☐ AM / PM ☐

When did you first obtain treatment from doctor? ☐☐☐☐☐☐☐☐ Time ☐☐☐☐ AM / PM ☐

Name of Doctor

Address

Is this doctor still treating you for the injury / illness? ☐ Yes ☐ No

Is this doctor your regular doctor? (If No, please give details) ☐ Yes ☐ No

Name of Regular Doctor

Address

Is there any condition (past or present) affecting your current disability? ☐ Yes ☐ No

If Yes, please give details

Are you now:

Recovered ☐ Yes ☐ No When did you return to work? ☐☐☐☐☐☐☐☐

Partially Disabled ☐ Yes ☐ No When did you return to work undertaking part of? ☐☐☐☐☐☐☐☐

Totally Disabled ☐ Yes ☐ No When do you expect to return to work? ☐☐☐☐☐☐☐☐

SECTION 5: TREATMENT RECEIVED (2 of 2)

Have you made, or will you make, a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury? ☐ Yes ☐ No

If Yes, please give details

	Claim Number (if known)	Name	Address
Employer			
Workers Comp / Transport Insurer			

Are you entitled to claim benefits for this Injury / Illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? ☐ Yes ☐ No

If Yes, please give details

Name	Address

SECTION 6: TO COMPLETED BY PERSON MAKING A CLAIM FOR DEATH BENEFIT

Name of Person Completing the Form:

Telephone Number:

Email address:

Company Name (If applicable) and Address :

Relationship with deceased – tick box below:

Employer ☐ Next of kin ☐ Executor ☐ Family Doctor ☐ Lawyer ☐ Other ☐

If next of kin, state relationship:

THE FOLLOWING DOCUMENTS MUST BE INCLUDED WITH THIS CLAIM:

- Certified copy Death Certificate.
- Certified copy of Original Birth Certificate
- Copy of the Coroner's Depositions & Findings (if applicable).

Was a coronial inquest held or is one being held ? ☐ Yes ☐ No

If so give details below:

Privacy Notice

Liberty International Underwriters (LIU) and Fullerton Health Corporate Services (FHCS) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information.

LIU collects personal information in order to provide insurance services and products and for ancillary business purposes and FHCS collects personal information in order to provide claim assessments and insurance related services. LIU and FHCS may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, UK, Singapore, Hong Kong and Malaysia.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from LIU and FHCS. If you do not provide the personal information LIU, FHCS or other relevant third parties require to offer you specific products or services, LIU or FHCS may not be able to provide the appropriate type or level of service.

If you wish to gain access to or correct your personal information, make a privacy complaint, or if you have any query about how LIU or FHCS collects or handles your personal information please write to LIU's Privacy Officer at privacy.officer.ap@libertyiu.com or call +61 2 8298 5800 and/or FHCS's Privacy Officer at privacy@csnet.com.au or call +612 8256 1770.

To obtain a copy of LIU's Privacy Policy go to LIU's website (www.liuaustralia.com.au) or request a copy from LIU's Privacy Officer.. To obtain a copy of FHCS's Privacy Policy go to FHCS's website (www.fullertonhealthcs.com.au) or request a copy from FHCS's Privacy Officer.

When you give LIU or FHCS personal or sensitive information about other individuals, LIU and FHCS rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, neither FHCS or LIU have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to FHCS or LIU using and disclosing my personal information pursuant to their 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 FHCS's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to FHCS or LIU such personal information (including health information) as FHCS or LIU 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 cooperation to FHCS 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 if I do not consent to the terms of this authority or revoke my consent, FHCS or LIU may not be able to process or assess my claim.

I appoint FHCS 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 (any adult person): _____ Date: ☐☐/☐☐/☐☐

Name of Witness: _____

SECTION 8: TO BE COMPLETED BY YOUR EMPLOYER

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

Employers Name:

This is to Certify that: has been unable to attend his/her occupation as a result of Injury or Sickness

From: Until:

His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was: AUD $:

Has your Employees last 12 months payroll history been attached with this report, and if not please provide ☐ Yes ☐ No

His / Her sick leave entitlement as at the date of injury or illness. Days:

He/She has been employed since Date:

Please confirm if he/she are still an Employee ☐ Yes ☐ No

Please confirm date they were no longer employed Date:

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/CTP? ☐ Yes ☐ No

SIGNATURE OF SUPERVISOR or MANAGER:

NAME OF SUPERVISOR or MANAGER: (PLEASE PRINT)

TELEPHONE NUMBER:

DATED:

The claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly

Patients Name | DOB: ☐☐ ☐☐ ☐☐☐☐

Height: | Weight:

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

Cause:

Is this condition ☐ an injury ☐ an illness

Does the patient have any other injury or illness that is contributing to the condition? ☐ Yes ☐ No

Provide Details

Is condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Provide Details

Was the disability sports related? ☐ Yes ☐ No

Provide Details

Date of onset/first symptoms? ☐☐ ☐☐ ☐☐☐☐

When did the patient first consult you for this condition? ☐☐ ☐☐ ☐☐☐☐

Has the patient ever had the same or similiar condition? ☐ Yes ☐ No

From when & diagnosis:

Name of patient's usual doctor/medical practice :

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

If the patient been hospitalized please provide; Admission Date ☐☐ ☐☐ ☐☐☐☐ Discharge Date ☐☐ ☐☐ ☐☐☐☐

Name of Hospital

Has the patient had surgery or is it anticipated? ☐ Yes No

Provide Details

Date performed or anticipated: ☐☐ ☐☐ ☐☐☐☐

Give name of hospital:

Please outline all treatment received to date in the management of your patient's condition. Please include any relevant medical documents, reports or investigative scans.

Was the patient referred by you or to you? ☐ Yes ☐ No

Provide Details

Doctors details

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 ☐☐ ☐☐ ☐☐☐☐

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? ☐ Yes ☐ No

Name of Company/Contact/Claim Number:

Signature of medical practitioner: Date: ☐☐ ☐☐ ☐☐☐☐

Name + Qualifications (print):

Address:

Telephone: