



Group Personal Accident & Sickness

About this claim form

- There are several sections for you to complete in full, as well as some for your employer. If you're self-employed, you'll need to fill in all these sections.
- To avoid delays with your claim, it's important that you provide answers to all the questions, including any additional documentation requested.
- The issue of this form is not an admission of liability.

Helpful instructions

We know that making a claim is often done at a stressful time and understand the importance of processing your claim as quickly as possible. Your claim will be managed by Proclaim Management Solutions (Proclaim), our trusted claims service provider, who is committed to ensuring your claim is handled efficiently, honestly, and fairly.

Sections 1 to 5	Please fully complete Sections 1 to 5 of this claim form, including either the sickness or injury statement.
Section 7	Sign the privacy declaration "Medical Authority and Declaration"
Section 8	If you're an employee , ask your employer to complete Section 8, and include 12 months payroll history prior to the date of your injury/sickness. If you're self-employed , please fill out Section 8 and provide your Tax Assessment Advice from the ATO for the previous financial year as proof of your income.
Section 9	"Medical Practitioner's Statement" is completed by your doctor.
Supporting documents	Attach any supporting documents you have for medical expenses to claim.

Ready to submit your claim form?

If so, please double check that you have followed all of the instructions, then send the completed claim form to ahclaims.au@libertyglobalgroup.com

You can fill out the form either electronically or by hand and if you have any questions regarding the completion of this claim form, please contact Proclaim on 1300 552 446 or +61 3 9660 5200.

1. POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

Employer's name		Policy #		
Title	Given name(s)	Male	Female	Prefer not to state
Family name		Date of birth		
Residential address				
Suburb		State	Postcode	
Postal address				
Do you consent to us communicating with you by email?		Yes	No	Email
Daytime contact number		Alternative number		
Occupation, trade or profession				
Work site/location				

2. EFT AUTHORISATION

I authorise and request that Proclaim credit the bank account as indicated below:

For direct/EFT payment

Account holder's name

BSB no

Account no

Bank

3. INJURY CLAIM

Date of injury	Time	AM	PM
Address where injury occurred			

Were there any witnesses to the incident? Yes No
If yes, please provide their details below:

Witness/s name

Witness/s address

Please describe how the injury occurred:

What were the injuries suffered?

Have you previously been treated for any serious injury?

Yes

No

If yes, please provide details below:

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

During the 24 hours before the injury, did you drink any alcohol or take any drugs and/or prescribed medication?

Yes

No

If yes, please state the type/s and quantities:

4. TO BE COMPLETED IF DISABILITY IS AS A RESULT OF A SICKNESS CLAIM

Describe the nature of the sickness:

When did the sickness begin?

Have you had this complaint before?

Yes

No

If yes, when?

and how long were you disabled?

5. TREATMENT RECEIVED FOR YOUR INJURY OR SICKNESS

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 a separate sheet if insufficient space)

From	To	Hospital name	Hospital address

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

Doctor's 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/sickness?		Yes	No
Is this doctor your regular doctor?		Yes	No
If no, please give details:			

Name of regular doctor
Address of regular doctor

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 working partial duties?
Totally disabled	Yes	No	When do you expect to return to work?

Have you made, or will you make, a claim for benefits under any Worker's Compensation Act or Transportation Act because of this injury/sickness?

Yes No

If yes, please give details:

	Claim no (if known)	Name	Address
Employer			
Workers' Comp/ transport insurer			

Are you entitled to claim benefits for this Injury/sickness from other insurers, persons, company, health fund, friendly society or government?

Yes No

If yes, please give details:

Name	Address

6. TO BE COMPLETED BY AUTHORISED PERSON MAKING A CLAIM FOR DEATH BENEFIT

Name of person completing the form

Telephone

Email

Company name (if applicable)

Address

Relationship with deceased Employer Next of kin Executor Lawyer Other

If next of kin, or other,
please state relationship

The following items must be included with this claim.

- Certified copy of original death certificate
- Certified copy of original birth certificate
- Copy of the Coroner's depositions of findings (if applicable)

Was a coronial inquest held, or is one being held?

Yes No

If yes, give details below:

7. MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither Proclaim Management Solutions (Proclaim) or Liberty Specialty Markets (Liberty) have accepted liability, nor waived any of their rights in respect of any claim arising under the policy.

I consent to Proclaim and/or Liberty using and disclosing my personal information in accordance with their respective privacy policies and this document. This consent remains valid unless I alter or revoke it by giving written notice to Proclaim's Privacy Officer.

I authorise any person or entity to provide to Proclaim or Liberty such personal information (including health information) as Proclaim or Liberty in its absolute discretion considers relevant for its assessment of my claim including my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to Liberty and Proclaim in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not deliberately 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, Proclaim or Liberty may not be able to process or assess my claim.

I appoint Proclaim 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.

Your signature

Date

Your name

Signature of witness (any adult person)

Date

Name of witness

Privacy Notice

Liberty Specialty Markets (Liberty) and Proclaim Management Solutions (Proclaim) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and Proclaim collects personal information in order to provide claim assessments and insurance related services. Liberty and Proclaim 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 Liberty and Proclaim. We will take appropriate measures to ensure your personal information remains protected and that the transfer complies with applicable data protection laws. This may include using standard contractual clauses or other lawful mechanisms to provide safeguards for the protection of your personal information. If you do not provide the personal information Liberty, Proclaim or other relevant third parties require to offer you specific products or services, Liberty or Proclaim 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 Liberty or Proclaim collects or handles your personal information please write to Liberty's Privacy Officer at privacy.officer.ap@libertyglobalgroup.com or call +61 2 8298 5800 and/or Proclaim's Data Protection Officer at GDPR.enquiries@dwf.law (please mark the subject heading of your email "For the attention of the Data Protection Officer") or call (toll free): +44 (0)333 320 2220.

To obtain a copy of Liberty's Privacy Policy go to Liberty's website (libertyspecialtymarkets.com.au) or request a copy from Liberty's Privacy Officer. To obtain a copy of Proclaim's Privacy Policy go to Proclaim's website (<https://proclaim.com.au/proclaim-privacy-policy>) or request a copy from Proclaim's Data Protection Officer.

When you give Liberty or Proclaim personal or sensitive information about other individuals, Liberty and Proclaim 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.

8. TO BE COMPLETED BY YOUR EMPLOYER

Employer's name

This is to certify that

has been unable to attend their occupation as a result of injury or sickness from until

Their average gross weekly salary (as defined by the policy wording) averaged over the previous 12 months at the time of this injury/sickness was \$

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

Their sick leave entitlement as at the date of injury or sickness days

They have been employed since

Please confirm if they are still an employee Yes No

Please confirm the date they were no longer employed

Has a claim for workers' compensation been lodged? Yes No

In the case of a motor vehicle accident, has a claim been lodged against the Traffic Accident Commission/CTP insurer? Yes No

Signature of supervisor or manager

Name of supervisor or manager (please print)

Telephone number Date

9. MEDICAL PRACTITIONER'S STATEMENT

This form should be fully completed. The patient is responsible for any fee incurred.

Patient's name	Date of birth
Height	Weight
Diagnosis (if fracture or dislocation, describe nature and location (i.e. simple, compound)	

Cause

Is this condition	An injury	A sickness
Does the patient have any other injury or sickness that is contributing to the condition?	Yes	No
Please provide details:		

Is condition due to injury or sickness arising out of the patient's employment?	Yes	No
Please provide details:		

Was the disability sports related?	Yes	No
Please provide details:		

Date of onset/first symptoms?		
When did the patient first consult with you for this condition?		
Has the patient ever had the same or similar condition?	Yes	No
If yes, please state when this occurred and the diagnosis:		

Name of patient's usual doctor/medical practice	
Length of time attending the usual doctor/medical practice?	
If the patient was hospitalised, please provide the admission date	and discharge date
Name of hospital	

Has the patient had surgery or is it anticipated?

Yes

No

Please provide details:

Date performed, or anticipated to be performed

Name of hospital

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?

Referred

Referring

Please provide details:

Doctor's 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 their current disability to be issued to any other insurance company, accident commission, workers' compensation insurer, government body, sports body or any other insurance body?

Yes

No

If yes, please provide the name of the company, the contact and claim number:

Name of company

Contact number

Claim number

Signature of medical practitioner

Name and qualifications (print)

Address

Telephone