Liberty Specialty Markets

Voluntary Worker

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 email address details, the injury statement and please **do not attach** accounts paid or part paid by Medicare
Section 6	Your organisation completes the section "Organisation Declaration".
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.

Save Print

Liberty Specialty Markets
c/- Proclaim Management Solutions
Locked Bag 32012, Collins St East, VIC 8003

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T: International +61 3 9660 5200
F: 1300 858 329 or +61 2 8551 8681
E: ahclaims.au@libertyglobalgroup.com

1. POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

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

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. DETAILS OF ACCIDENT & INJURY

Date of accident Time AM ☐ PM ☐

Address where accident occurred

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

Witness name(s)

Witness address

Please describe how the accident/injury occurred:

What were the injuries suffered?

Have you previously been treated for the same or a similar injury? Yes ☐ No ☐

If yes, please give details:

Provide details of any previous claim made for any previous injury against any insurance company:
(Please attach separate sheet if insufficient space)

During the 24 hours before the injury, did you drink any alcohol or take any drug(s) and/or prescribed medication? Yes ☐ No ☐

If yes, please state types and quantities:

4. TREATMENT RECEIVED

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

When did you first obtain treatment? Time AM ☐ PM ☐

Name of current treating doctor

Clinic name/address

Name of regular doctor

Clinic name/address

Date first consulted doctor Date last consulted doctor

How long have they been your regular doctor? Years Months

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

5. NON-MEDICARE MEDICAL EXPENSES

The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap or the Medicare out of pocket amount, and do not attach accounts paid or part paid by Medicare).

Are you a member of an ambulance service? Yes ☐ No ☐

If yes, please give details:

Are you a member of a private health fund? Yes ☐ No ☐

If yes, please give details:

Does your private health insurance have hospital cover? Yes ☐ No ☐

Does your private health insurance cover extras (physio etc.)? Yes ☐ No ☐

Name of provider	Service (e.g. physio)	Date of service	Charged amount	Private health rebate	Amount claimable A$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$
			$	$	$

Total	$ 0.00
Less excess	$
Total amount of claim	$ 0.00

6. ORGANISATION DECLARATION

Organisation name

Organisation official's name

Organisation official's position

Address

Suburb | State | Postcode

Daytime contact number | Email (important)

I, the above mentioned Organisation Official, confirm that

(Member's name) was a

Voluntary worker for the organisation and was an insured person as identified in the Personal Accident Insurance with Liberty Specialty Markets at the time of the accident. The information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Are there any comments in relation to this claim? Yes ☐ No ☐

If yes, please give details:

Signature of official | Date

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.

Signature of claimant	Date
Name of claimant	

Signature of witness (any adult person)	Date
Name of witness	

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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