St Andrew's
AUSTRALIA

# INITIAL ACCIDENT AND SICKNESS CLAIM FORM

**Please complete this claim form and return to:**

**The Claims Department**
**St Andrew's Australia**
**PO Box 7395**
**Cloisters Square 6850**

**If you have any queries regarding your claim, please contact us on 1300 653 751 or claims@standrews.com.au**

**IMPORTANT INFORMATION**

1. **The issue of this claim form is not an admission of liability**
2. **It is a condition of your policy that you provide a fully completed claim form as quickly as possible. A delay in submitting this form may prejudice your entitlement to a claim.**
3. **Please ensure that all questions are fully answered to avoid any delay in the handling of your claim.**
4. **If you do not complete all relevant sections of your claim form we may have to return it to you to be fully completed and your claim may be delayed.**
5. **It may be necessary during the period of your claim for a company representative to call you.**
6. **It is important that you notify us of any change in circumstances during your claim at the earliest opportunity, such as a return to employment.**
7. **If there is not enough room within the form to provide your responses please attach any documentation/word document that will aid us in assessing your claim.**

# INITIAL ACCIDENT AND SICKNESS CLAIM FORM

Insured to complete

## Details of Insured

1. Claim Number(s)
2. Date of Birth (dd/mm/yy): / /
3. Surname:
4. First Names:
5. Residential Address:

   Suburb/State/Postcode:
6. Phone: Home: Mobile:
7. Email:

### Medical Details

8. What medical condition are you currently suffering from?
9. When did you cease work due to your condition? ..... / /
10. If your condition was caused by an injury/accident please provide details and date of event or if you are suffering from an illness, what are your symptoms and when did you first notice symptoms?
11. When did you first consult your usual General Practitioner for this condition? ..... / /
12. Please provide details of all treatment (including chiropractors, physiotherapist and medication) that you have had for this condition?

| Date | Contact details |
|---|---|
| / / | |
| / / | |

13. Have you returned to work?

    Yes – What date did you return to work? ..... / /

    No – When do you expect to return to work? ..... / /

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## Occupational Details

**14.** What was your occupation immediately prior to ceasing work?

**15.** How many hours per week do you work: pw

**16.** Please provide details of your occupational duties and % of time spent performing those duties:

| Duties: eg computer work | % of time performing duties eg 55% |
|---|---|
| | |
| | |
| | |

**17.** Please detail your work experience history for the last 3 years

| | | | |
|---|---|---|---|
| Occupation | | Years spent in role | |
| Occupation | | Years spent in role | |
| Occupation | | Years spent in role | |

**18.** Please provide the name and address of your employer prior to ceasing work (if you are an employee)

Employers Name:

Address:

Phone:

***Only complete the next section if you are self-employed. Otherwise go to Q21.***

**19.** If you are self-employed please provide the following details

Do you trade as: Sole Trader ☐ Partnership ☐ Company ☐ or via a Trust ☐

Name of Employing Entity:

Address:

Phone:

Nature of business:

Date Trading commenced..... / /

ABN

Has trading ceased

Are you in receipt of any remuneration from the business? ..... Yes ☐ No ☐

**20.** What is your involvement in the business post your accident or sickness?

We may need to request your Income Tax Return, Notice of Assessment and other financial information.

## Other Information - all claimants must complete

**21.** Are you making any other insurance claims in respect of this condition?

If yes, please provide details, name of insurance company, type of claim, claim number

**22.** a) Are you entitled to claim an Input Tax Credit on this policy? ..... Yes ☐ No ☐

In general; you can only claim an ITC if you are claiming the premiums for this policy as a business expense

b) If yes, please provide your Input Tax Credit Entitlement ..... %

**Non-medical Authority (a separate Medical Authority following on page 6)**

I authorise any other insurance company, which I have made a claim under for this condition, and my most recent employer to release to:

- St Andrew's; and/or
- Its Authorised representative;

all information requested by St Andrew's so that they can assess this claim.

I agree that a photocopy or a scanned, electronic copy of this authorisation shall be as effective and valid as the original.

Signature of Insured ✗ Date (dd/mm/yy) / /

Name of Insured

**Privacy Policy Statement**

We collect your personal information so that we can process your claim, identify you for inquiries you may have, and tell you about our products and services. With respect to your claim, we will need to collect sensitive information related to your health.

By providing your information, you consent to us:

1. collecting, using and disclosing your information in accordance with our Privacy Policy; and
2. disclosing your information to third parties (such as insurers, medical professionals and ex-employers) in relation to your claim.

Our Privacy Policy can be found at www.standrews.com.au, and describes how we deal with your personal information. Please refer to our Privacy Policy for how you can access and correct your information, and for our complaints procedure.

You may contact our Privacy Officer on 1300 363 159 or standrews@standrews.com.au during normal business hours (and to opt-out of marketing). If you provide us with personal information about someone else, please ensure you have their consent to do so.

**Declaration**

I declare that the information contained in this statement is true, complete and correct in every detail. I understand that if I do not give full particulars or if I provide incorrect information my rights to obtain benefits under the policy may be prejudiced.

Signature of Insured ✗ Date (dd/mm/yy) / /

Name of Insured

**Checklist –** Please ensure all the relevant sections are completed and attached.

**IMPORTANT NOTE:** You MUST complete Medical Authority 1 **OR** Medical Authority 1 and Medical Authority 2 on page 6.

- ☐ Insured Section including Authorities
- ☐ Employer's Section
- ☐ Doctor's Section – including attachments

## Consent wording (for living adults)

### Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We, St Andrew's, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

**Authority 1 explanatory notes** – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

**Authority 2 explanatory notes** – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

## Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to St Andrew's, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form St Andrew's asks for, such as a general report, a report about a specific condition,
  my records in SafeScript, any hospital notes, or correspondence between health providers.
- St Andrew's can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while St Andrew's is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature ✗ Date (dd/mm/yy) / /

## Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to St Andrew's, or to third parties they engage, only if St Andrew's has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- St Andrew's can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while St Andrew's is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature ✗ Date (dd/mm/yy) / /

# INITIAL ACCIDENT AND SICKNESS CLAIM FORM

Employer to complete – Insured to pass to employer and return.

## Employer's Section

1. Employees full name

2. Occupation

3. Date employment commenced: ..... / /

4. Number of hours worked: ..... pw

5. Date last worked: ..... / /

6. Reason employee ceased work?

7. If the employee has ceased work due to an accident, have the details been reported via the normal channels? ..... ☐ Yes ☐ No

8. Has the employee previously suffered from this injury or sickness whilst working for you ..... ☐ Yes ☐ No

   If yes, please provide details and dates:

   Condition ____ Date from ____ to ____

9. Is the employee still in your employment? ..... ☐ Yes ☐ No

10. If no, please provide reasons for leaving and last date of employment

Signature ✗ Date (dd/mm/yy) / /

Name

Position

Name and address of Employer

Left blank intentionally.

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# INITIAL ACCIDENT AND SICKNESS CLAIM FORM

DOCTOR'S SECTION – Insured to pass to Doctor and return

- All questions must be completed by a medical practitioner.
- Any costs associated with the completion of this form are to be met by the patient.
- Please complete and return to the patient.
- A copy of this statement and any other report you provide may be passed to other parties reasonably deemed necessary for the assessment of the patient's claim.

Patient's Name:

Date of birth (dd/mm/yy): / /

Residential Address:

Suburb/Town: State: Postcode:

Date you last examined the patient (dd/mm/yy): / /

**1.** How long has this patient been attending this medical practice (when did the records commence)?

**2.** When did the patient first consult you for this condition?

**3.** Primary Diagnosis;

**4.** Secondary Diagnosis if applicable

**5.** Date your patient became unfit for work due to the diagnosis? ..... / /

**6.** Please list and describe the current symptoms and severity

**7.** What is your understanding of how the condition arose?

**8.** What are the predisposing causal factors (if any) associated with the patient's condition

**9.** Is your patient totally incapacitated and unable to perform their usual occupational duties due to their condition?

**10.** When do you anticipate your patient will be able to return to work?

**11.** Has your patient previously consulted you or any other Doctor with symptoms of this or any other similar condition?
If yes please provide details

**12.** What is the current treatment/proposed treatment?

**Additional Details/Comments**

**Declaration**

I certify I have personally attended the above patient and that all the information supplied by me on this patient is true and correct to the best of my knowledge and belief.

| | | | |
|---|---|---|---|
| Signature of Doctor | ✗ | Date (dd/mm/yy) | / / |
| Name | | | |
| Qualifications | | | |
| Surgery Address | | | |
| Suburb/Town | | State: | Postcode: |
| Phone | | Fax: | |
| Email Address | | | |



St Andrew's Insurance (Australia) Pty Ltd ABN 89 075 044 656 AFSL 239649
St Andrew's Life Insurance Pty Ltd ABN 98 105 176 243 AFSL 281731

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# YOUR ACCIDENT & SICKNESS CLAIM
## Frequently Asked Questions

We are sorry to hear you have been unwell. We hope that you find your claims experience a smooth and efficient process. Within this helpsheet you will find information that will assist you through every stage of your claim.

### How to contact us
By post: Claims Team, PO Box 7395, Cloisters Square, WA 6850
By phone: Claims Team 1300 653 751*
By email: claims@standrews.com.au
Our claim assessors are here to help you Monday to Friday from 8am to 4pm (WST).
*Telephone calls may be monitored to assist with training and for quality control purposes

### After lodging the claim when will I receive a response?
We assess all new claims within 3-5 working days of receipt. You will be informed of the next steps within this time frame. We will assess any information received after our initial assessment within 3-5 workings days.

### When will I be considered unfit for work?
For the purpose of your policy, you first become unfit for work on the day you first consult or receive treatment from a Qualified Medical Practitioner and are certified by that person to be unfit for work.

### How long do I have to be unfit for work before payments are made?
There is a 30 day waiting period in which no benefits are payable. The 30 day waiting period commences from the date you were first certified unfit for work. In addition you must be unfit for work for the full 30 day waiting period. Benefits start to accrue from the 31st day and are payable monthly in arrears.

### Where are the payments sent?
Your policy provides cover for repayments on your Agreement whilst you are unfit for work where an insured event occurs. Payments are generally therefore sent to your financier to credit your linked mortgage, loan or credit card as appropriate. If you have kept up your repayments and you would like a refund of any duplicated payments, please discuss this with your financier.

### After the first payment, what happens for the following months?
If you remain unfit for work, continuing payments are made by providing us with a continuation form completed by you and your GP. We will send you these forms when a payment is made. Once the forms are received, assessment of your ongoing entitlement will be made within 3 days. Please note that assessment of the claim may mean that further information is required before a payment can be approved.

### How frequently will my claim be paid?
The payments we make are based on the period of certification confirmed to us by your GP on each of your continuation forms and your declaration that you did not return to work during this period.

### What is the maximum period I can claim for?
Most policies we handle pay for a maximum of 36 monthly benefits. Please check your relevant Product Disclosure Statement or call our Claims Team to check the maximum payable on your policy.

### What happens if my circumstances change?
Please keep us informed of any changes to your circumstances. This includes change of address, going away on holiday and your return to employment.

This is a brief summary/reference guide only. Please refer to the Product Disclosure Statement for further information about this product or the claims process.

St Andrew's Insurance (Australia) Pty Ltd ABN 89 075 044 656
St Andrew's Life Insurance Pty Ltd ABN 98 105 176 243

# Accident & Sickness Claims Process