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 you claim you can contact St Andrew's on
Ph: 1300 653 751 or fax 1300 552 695 or email: 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 (within 120 days of the claim commencement date). 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.

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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/Town:
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 please go to question 21 'Other Information'.*

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?

Other Information

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 ☐

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

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Authority

I authorise any doctor, hospital, dentist, allied health professional insurer, other person whom I have consulted or has attended to me and other insurance companies to release to:

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

all information with respect to any illness, accident or injury, medical consultation, prescriptions or treatment and copies of all hospital records or medical records, reports or notes.

I agree that a photocopy or a scanned, electronic copy of this authorisiation 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 attached.
Treating Doctors Section completed and attached

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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

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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			