Directors Personal Accident and/or Sickness Insurance

Claims form

Issued by Agile Underwriting Services Pty Ltd ABN 48 607 908 243 - AFSL 483374





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Important Information

- Please complete all relevant sections of this claim form and provide any supporting documentation to ensure prompt payment of your claim
- This clam form can be completed and sent electronically. Alternatively you can manually complete this claim form and email it to ahclaims@agileunderwriting.com
- We take your privacy very seriously. If you would like to review our Privacy Policy you can call us on 1300 705 031 or email us at <u>privacy@agileunderwriting.com</u> or visit our website <u>www.agileunderwriting.com</u>
- Refer to the checklist to make sure you have provided all necessary documentation for your claim

Checklist

- □ Medical certificate
- □ Medical reports
- □ Hospital admission/discharge documents
- $\hfill\square$ Completed all relevant sections of this claim form
- □ All original supporting documentation has been provided
- □ You have signed this claim form

Section 1 – Policy Details

Policy Number:	Expiry Date:	Member Number (if applicable):
	/ /	
Name of Insurance Broker (if known):	Name of Insured Comp	bany:

Section 2 – Personal Details

Title:	Given Name(s)	Gender: Male □ Female □
Family Nam	le:	Date of birth:
		/ /

Contact details:

Street Address:

City:			State:	Postcode:
Telephone number:	Alternative Contact Number:	Email address	5:	1



Section 3 – Claim Details

Did you suffer an injury or sickness?	Date of inju	ry/sickness:	Time of injury/sickness (24-hour clock):
□ Injury □ Sickness	/	/	:

Address or place of injury/sickness:

City:				State:	Postcode:
Did an	yone wi	tness the accident?	Full Na	ame:	1
□ Yes	🗆 No	If 'Yes,' provide details:			

Street Address:

City:	State:	Post	tcode:
Have you suffered from this injury/sickness in the	past?	Yes 🗆	No 🗆
If 'Yes,' please provide details:			

Do you consider anyone to blame for the injury or sickness?
Yes □ No □

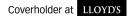
If 'Yes,' please provide details:
Phone Number:

Name of Insurer/Company/ Individual:
Phone Number:

Street Address:
City:

City:
State:

How did the injury/sickness occur?





What injuries/sickness did you sustain?

Please provide details of any previous claims made against any insurance company for any previous injury or sickness:

Section 4 – Employment Details

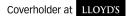
Occupation:				
General Duties:				
Have you missed time at work due to your inj	ury/sickness?		Yes 🗆	No 🗆
Contact details of your employer:				
Company Name:		Phone Number:		
Street Address:				
City:	State:		Postco	de:
		From:	To:	
Period of employment: (DD/MM/YY)		/ /	/	/
Date you ceased working due to your injury/	sickness:		/	/
Have you returned to work?			Yes 🗆	No 🗆
If 'Yes,' when did you return to work?	If 'No', when do	you hope to do so?		
	/	/		



Section 5 – Treatment Details

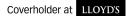
Nere you hospitalised as a result of your injury/sickness? f 'Yes', please provide details:			Y	es 🗆 No				
Name of Hospital:				Name of atten	iding doctors or ph	ysicians	5:	
Date Admitted:	/	/		Date Released	l:	/	/	
When did you first obtain treatment from a doctor?	/	/		Name of docto	or:			
Street Address:								
City:				State:			Postcode	e:
Is the doctor still treating you	ı for yoı	ur injury/	sick	ness?		Ye	es 🗆 No	
Is the doctor your regular doc	tor?					Y	es 🗆 No	
If 'No,' please provide details:								
Name of regular doctor:					Phone Number:			
Street Address:								
City:			Sta	te:			Postcode	e:
Is there any condition (past o	r preser	nt) affect	ing y	our current	t disability?	Y	es 🗆 No	

If 'Yes,' please provide details:





Are you now:			When did you return to work?		/	/
Recovered	Yes 🗆	No 🗆	When did you return to	work undertaking		
Partially Disabled	Yes 🗆	No 🗆	When did you return to partial duties?	work undertaking	/	/
Totally Disabled	Yes 🗆	No 🗆	When do you expect to	When do you expect to return to work?		/
Have you made, or w	ill you mal	ke, a claiı	m for benefits under a	ny Workers		
Compensation Act or	⁻ Transport	ation Act	t due to this injury/sic	kness?	Yes 🗆	No 🗆
If 'Yes,' please provide de	etails:					
Claim Number (If Know	'n):		Policy Number (If Know	n):		
Name:			Street Address:			
City:				State:	Pos	tcode:
Are you entitled to cl	aim for thi	s injury/s	sickness from any oth	er Insurer(s),		
person(s), Company(s), Health	Fund(s),	Friendly Society or Go	overnment?	Yes 🗆	No 🗆
If 'Yes,' please provide de						
Name:			Street Address:			
City:				State:	Pos	tcode:



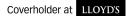


Section 6 – Income Details

		Yes 🗆	No [
mployed, confirmation of earnings MUST be submitted with claim form			
ome Tax Return & Profit/Loss Statement			
llowing is to be completed by your employer if you are employ	yed as a wag	e earner	
also attach pay slip).			
y certify that has been unable to atte	nd their usual	occupatio	n with
		occupatio	
npany as a result of an injury/sickness suffered whilst		on the	
/ They have been incapacitated since/ a	and is expected	d to/and re	esumed
on/ Their Gross Salary (exclusive of bonuses, comm	ission allowar	nces etc.) :	at the
	1551011, allowall	ices etc.) a	it the
injury/sickness was \$per week.			
	om:	To:	
g the period of incapacity, they received $\$$	/ /	/	/
specify type of pay			
of Company: Has be	een employed :	since:	
	/ /		
Address:	, ,		
State:		Pos	code:
		Pos	51

Signature of Supervisor or Paymaster:

Name:	Date: (DD/MM/YY)	Phone Number:
	/ /	
Signature:	Email Address:	I





Section 7 – Payment Details

Please provide your banks details where you would like your claim payment to be transferred:

Account Holder's Name:

Name of Bank:	BSB Number:	Account Number:

Declaration

Privacy Declaration

I/We agree that, by submitting this form, the personal information I/we provide to Agile in this form or otherwise may be collected, held, used and disclosed in the manner set out in our Privacy Policy, including for the processing of this claim. Yes \Box

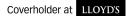
Declaration

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed. Yes \Box

Authority

I/We authorise any hospital and/or physician who has treated me to provide Agile with copies of medical records or of my past medical history, as requested. Yes □

Name of Claimant:	Signature of Claimant:	Date: (DD/MM/YY)		
		/ /		
Name of Insured (if other than claimant):	Signature of Insured (if other than claimant):	Date: (DD/MM/YY)		
		/ /		





Medical Certificate

Patients Details

Name:	Date of birth:
	/ /

Please provide complete diagnosis of condition:

History

When did the patient first receive medical treatment?	/	/
Is there a previous history of this or a similar condition?	Yes 🗆	No 🗆

If 'Yes,' please provide details:

How long have you known the patient?	Days:	Months:	Years:
Are you the regular general Yes □ No □	If 'No,' please advis	e who is:	

Injury

When did the patient first suffer the injury?				/	/													
				e		•												

What was the cause of the injury?

Sickness

When was sickness first contracted?	When did the symptoms become evident?					
/	/ /					

Degree of Disability

When was patient obliged to cease work?		/ /
When were / will the notion the / able to veture to werk?	Some Duties:	Full Duties:
When was / will the patient be / able to return to work?	/ /	/ /



Treatment of	f Present Cond	ition						
When were you	ı consulted?			Initially:	М	ost recently: / /		
Was patient co	nfined to hospital	? Yes□ No			ease hospital details:			
From: / /	To:	Name of Hospital:						
Hospital Address:								
City:				State:		Postcode:		
What other surg	ical or medical pro	ocedures are possib	ly contei	mplated?				
the current cond	dition?	ns affecting recover underlying condition(s		they may affect di		es □ No □ and recovery:		
What is the curr	ent prognosis?							
Are there any fu	rther remarks wh	ich may assist in as	sessing tl	nis condition?				
Declaration								
Name:			Qualifica	ition:				
Street Address:								
City:				State:		Postcode:		
Email address:								
Contact Number:		Signature:			Date:	(DD/MM/YY)		
						/ /		

