Group Personal Accident and/or Sickness Insurance

Claims form

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

Personal Accident & Sickness

Accident & Health

Powered by AGILE. Coverholder at LLOYD'S

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 privacy@agileunderwriting.com or visit our website www.agileunderwriting.com
- 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
- ☐ 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 Company:	

Section 2 – Personal Details

Title:	Given Name(s)	Gender: Male ☐ Female ☐
Family Name:		Date of birth: / /

Contact details:

Street Address:

City:	State:	Postcode:

Telephone number:	Alternative Contact Number:	Email address:

Section 3 – Claim Details

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

Address or place of injury/sickness:

City:	State:	Postcode:

Did anyone witness the accident? ☐ Yes ☐ No If 'Yes,' provide details:	Full Name:

Street Address:

City:	State:	Postcode:

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:

Name of Insurer/Company/ Individual:	Phone Number:

Street Address:

City:	State:	Postcode:

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 injury/sickness?	Yes ☐ No ☐

Contact details of your employer:

Company Name:	Phone Number:

Street Address:

City:	State:	Postcode:

Period of employment: (DD/MM/YY)	From: / /	To: / /
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

Were you hospitalised as a result of your injury/sickness? Yes ☐ No ☐

If 'Yes', please provide details:

Name of Hospital:	Name of attending doctors or physicians:
Date Admitted: / /	Date Released: / /
When did you first obtain treatment from a doctor? / /	Name of doctor:

Street Address:

City:	State:	Postcode:

Is the doctor still treating you for your injury/sickness? Yes ☐ No ☐

Is the doctor your regular doctor? Yes ☐ No ☐

If 'No,' please provide details:

Name of regular doctor:	Phone Number:

Street Address:

City:	State:	Postcode:

Is there any condition (past or present) affecting your current disability? Yes ☐ No ☐

If 'Yes,' please provide details:

Are you now:				
Recovered	Yes ☐	No ☐	When did you return to work?	/ /
Partially Disabled	Yes ☐	No ☐	When did you return to work undertaking 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 Workers Compensation Act or Transportation Act due to this injury/sickness? Yes ☐ No ☐

If 'Yes,' please provide details:

Claim Number (If Known):	Policy Number (If Known):	
Name:	Street Address:	
City:	State:	Postcode:

Are you entitled to claim for this injury/sickness from any other Insurer(s), person(s), Company(s), Health Fund(s), Friendly Society or Government? Yes ☐ No ☐

If 'Yes,' please provide details:

Name:	Street Address:	
City:	State:	Postcode:

Section 6 – Income Details

Are you self-employed? Yes ☐ No ☐

If self-employed, confirmation of earnings MUST be submitted with claim form
i.e. Income Tax Return & Profit/Loss Statement

The following is to be completed by your employer if you are employed as a wage earner
(please also attach pay slip).

I hereby certify that _____ has been unable to attend their usual occupation with the company as a result of an injury/sickness suffered whilst _____ on the _____/_____/_____. They have been incapacitated since _____/_____/_____ and is expected to/and resumed duties on _____/_____/_____. Their Gross Salary (exclusive of bonuses, commission, allowances etc.) at the date of injury/sickness was $_____ per week.

During the period of incapacity, they received $	From: / /	To: / /

Please specify type of pay _____.

Name of Company:	Has been employed since: / /
Street Address:	

City:	State:	Postcode:

Signature of Supervisor or Paymaster:

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

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 ☐

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 ☐

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 practitioner? Yes ☐ No ☐	If 'No,' please advise who is:		

Injury

When did the patient first suffer the injury?	/ /

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 was / will the patient be / able to return to work?	Some Duties: / /	Full Duties: / /

Treatment of Present Condition

When were you consulted?	Initially: / /	Most recently: / /

Was patient confined to hospital? Yes ☐ No ☐ If 'Yes,' please hospital details:

From: / /	To: / /	Name of Hospital:

Hospital Address:

City:	State:	Postcode:

What other surgical or medical procedures are possibly contemplated?

Are there any underlying conditions affecting recovery from the current condition? Yes ☐ No ☐

If 'Yes,' please advise the nature of the underlying condition(s) and how they may affect disability and recovery:

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Declaration

Name:	Qualification:

Street Address:

City:	State:	Postcode:

Email address:

Contact Number:	Signature:	Date: (DD/MM/YY) / /