Volunteers Personal Accident and/or Sickness Insurance

Claims form

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





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 <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 Com	pany:

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	:	



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:	
□ Yes	🗆 No	If 'Yes,' provide details:			

Street Address:

City:	State:	Pos	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 □

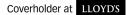
If 'Yes,' please provide details:
Phone Number:

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

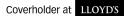
Occupation:				
General Duties:				
Have you missed time at work due to your inj	ury/sickness?		Yes 🗆	No 🗆
Contact details of your employer:				
Company Name:		Phone Number:		
Street Address:				
City:	State:		Postco	de:
Deviad of employments (55 (444)		From:	To:	
Period of employment: (DD/MM/YY)		/ /	/	/
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

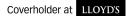
Were you hospitalised as a result of your injury/sickness? If 'Yes', please provide details:			Y	es 🗆 No 🗆		
Name of Hospital:			Name of atte	nding doctors or ph	ysician	5:
Date Admitted:	/	/	Date Release	d:	/	/
When did you first obtain treatment from a doctor?	/	/	Name of doct	or:		
Street Address:						
City:			State:			Postcode:
Is the doctor still treating you	ມ for you	ır injury/si	ckness?		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:		:	State:			Postcode:
Is there any condition (past o	r presen	it) affectin	g your curren	t disability?	Y	es 🗆 No 🗆

If 'Yes,' please provide details:





Are you now:	V -		When did you return to work?		/	/
Recovered	Yes 🗆	No 🗆	When did you return to	work undertaking		
Partially Disabled	Yes 🗆	No 🗆	partial duties?	5	/	/
Totally Disabled	Yes 🗆	No 🗆	When do you expect to return to work?		/	/
Have you made, or w	ill you mal	ke, a clair	n for benefits under a	ny Workers	Yes 🗆	No 🗆
Compensation Act or	Transport	ation Act	t due to this injury/sic	kness?		
If 'Yes,' please provide de	etails:					
Claim Number (If Know	n):		Policy Number (If Know	n):		
Name:			Street Address:			
City:				State:	Post	tcode:
-	s), Health		sickness from any othe Friendly Society or Go		Yes 🗆	No 🗆
Name:			Street Address:			
City:				State:	Pos	tcode:



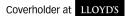


Section 6 – Income Details

Are you self-employed?			Yes	🗆 No 🗆
If self-employed, confirmation of earnings MUST be submitted w	/ith claim fo	orm		
i.e. Income Tax Return & Profit/Loss Statement				
The following is to be completed by your employer if y	ou are em	ployed as a wa	age earr	ner
(please also attach pay slip).				
I hereby certify that has bee	en unable to	attend their usu	ial occup	ation with
the company as a result of an injury/sickness suffered whilst			on t	he
/ They have been incapacitated since	.//	and is expect	ted to/an	d resumed
duties on/ Their Gross Salary (exclusive of	bonuses, co	ommission, allow	ances et	c.) at the
date of injury/sickness was \$per week.				
		From:	To:	
During the period of incapacity, they received $\$$		/ /		/ /
Please specify type of pay				
Name of Company:	Н	as been employe	ed since:	
		/ /		
Street Address:	I			
City:	St	tate:	F	Postcode:

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?	/	,	/
will be a second of the factor of the second			

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 nations he / able to yeturn to werk?	Some Duties:	Full Duties:
When was / will the patient be / able to return to work?	/ /	/ /



Treatment of	f Present Con	dition					
When were you consulted?				Initially: / /	М	ost recently: / /	:
Was patient co	nfined to hospita	l? Yes□ No		If 'Yes,' please	e hospit	al details:	
From:	То:	Name of Hospital:					
/ / Hospital Address							
City:			5	State:		Postcode:	
			-				
What other surg	gical or medical p	rocedures are possib	oly contem	plated?			
Are there any un the current con		ons affecting recove	ry from		Y	es 🗆 No 🗆	J
		e underlying condition(s) and how t	hey may affect di	sability	and recovery	<i>'</i> :
What is the curr	ent prognosis?						
		hich may assist in as	:				
Are there any fu	irther remarks w	nich may assist in as	sessing thi	s condition:			
Declaration							
Declaration Name:			Qualificat	ification:			
Street Address:			1				
City:				State:		Postcode:	
-							
Email address:				1		1	
Contact Number:		Signature:			Date:	(DD/MM/YY)	
						/ /	

