

Claim Report

Information Authority and Warranty

I,

hereby authorise any hospital, physician or other person who has attended me, to furnish Chartis Australia Insurance Limited or its representatives with:-

- (i) Copies of hospital and medical reports/notes; and
- (ii) All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original and specifically authorise its use as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that Chartis Australia Insurance Limited relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Privacy Consent:

I consent to Chartis:

- (a) Collecting and using my personal information for the purposes of administering my claim including investigating, assessing and paying any claim made by me or on my behalf. (If we do not collect this information we may not be able to process your claim.)
- (b) Disclosing my personal information to related entities of Chartis, their staff members located outside Australia, the insured (if not myself), other insurers and reinsurers, insurance reference bureaus, law enforcement agencies, investigators, lawyers, assessors, repairers, advisors and the agent of any of these, insurance broker, insurance agent or other intermediary, my employer or Financial Ombudsman Service Limited (FOS) for the purposes of administering my claim or providing a report.
- (c) I understand that a copy of the Chartis privacy policy statement, including information about access, may be obtained by writing to: The Privacy Manager, Chartis, GPO Box 4363, Melbourne VIC 3001, or by downloading from Chartis website www.chartisinsurance.com.au

Name	<input type="text" value="Please Print"/>	Signature
Date	<input type="text" value="/ /"/>	

If you will follow these simple instructions, we will be able to give your advice immediate attention when we receive this form

- If you have suffered a condition covered by the policy, complete this form as soon as possible after diagnosis and/or Bed Care. Answer every question completely and accurately, then give this form to your doctor.
- Ask your doctor to answer all questions on the opposite page.
- Arrange completion of the Certificate of Bed Care.
- After both you and your doctor have answered all questions and you have had the Certificate of Bed Care completed, send the completed forms to the address on the front of this form. The furnishing of this form does not constitute an admission of liability.

Continued Over Page

Employer or Group

Full Policy Number with Prefix Certificate Number

Full Name of Member Phone

Full Name of Patient

Phone Date of Birth

Residential Address Postcode

Patient's Relationship to Member Patient's Occupation

1. When did accident occur

2. Describe the accident

3. Describe injury

4. When did you first see a doctor for this condition
Doctor's name and address

5. Dates hospitalised: Admitted Discharged
Name and address of Hospital

6. If confinement in convalescent home after hospitalisation was necessary, give:

a. Date of confinement 20 to 20

b. Where (Name & Address)

7. Have you ever seen a doctor for this or similar condition in the past? YES / NO
(If "yes" give dates, names and addresses of doctors)

8. Name and address of regular family physician
 Phone

Electronic Funds Transfer (EFT) details

1. Do you want the benefit to be deposited directly into a financial institution account via EFT? YES / NO

2. Name the account is held in:

3. BSB number (6 digits in total) Financial institution account number (up to 9 digits only)

(If you are unsure of the BSB number, please contact the financial institution where the account is held.)

4. Financial Institution: Branch:

This form must be completed without expense to the Insurer

Attending Physician's Statement

Patient's Name Age

1. If injury, when did accident occur? / /

2. Diagnosis, chief complaint, history, complications and list any fractures

3. When did patient first receive medical attention for the above? / /

By whom?

4. Dates hospitalised: Admitted / / Discharged / /

Name and location of hospital

5. What operation, if any, was performed?

6. Name, addresses and specialities of other doctors in attendance or consultation:

7. Was confinement in a convalescent home necessary after hospitalisation?

If "yes", please give dates: From to to 20

Date discharged from your care 20

8. Has patient ever had same or similar conditions? (if "yes" give dates and describe)

9. Have you previously treated this patient? When? / /

For What?

10. Has patient been diagnosed with osteoporosis? If so, date of diagnosis. / /

11. What defects or chronic disease does patient have and when did they originate? (Use this space to amplify)

12. Degree of Temporary Disability: Based on Patient's occupation of

a. Has the patient been able to do any work? Full Duties Suitable Duties

b. If so, from what date? / / / /

c. If not, when will he/she be able to work? (Approximately) / / / /

13. Has injury described in 1. Above resulted in any residual disability? If "yes", please give details

Signed Name

Date / / Qualifications Phone Number

Address

This form must be completed without expense to the Insurer

Certificate of Bed Care

This hereby confirms that

Was/is under the continuous care of a registered nurse for days

from

 / /

time

 :

AM / PM

to

 / /

time

 :

AM / PM

Place of continuous care:

Nature of condition:

Signature

Signature

Name

Please Print

Date

 / /

Title/Qualifications

Telephone No:

 []

Address

PLEASE KEEP A PHOTOCOPY OF ALL DOCUMENTATION YOU SEND TO US FOR YOUR OWN RECORD

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