QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

QBE Commercial

Accident/Illness Claim

The issue of this form does not constitute an admission of liability on the part of the insurer. Please complete all sections

Policy No.		Claim No.	

INSURED DETAILS

Insured	Surname		Given Name(s)				
Claimant	Surname		Given Name(s)				
Are You Registered for GST?	No ☐ Yes ☐	What is your ABN?					
Have you claimed or intend to claim an input tax credit on the GST component of the premium applicable to this Policy?	No ☐ Yes ☐ – Will you be claiming an amount less than 100%?						
	No ☐ Yes ☐ – Specify amount claimed	%					
Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?	No ☐ Yes ☐ – Will you be claiming an amount less than 100%?						
	No ☐ Yes ☐ – Specify amount claimed	%					
Address							
		State		Postcode			
Contact Numbers	Home	( )	Work	( )			
	Mobile		Email				
Date of Birth	/ /	Height	cm	Weight	kgs	Sex	Male ☐ Female ☐
Occupation		Describe your usual duties					

INJURY/ILLNESS DETAILS

1. Give a full description below of injury or illness for which you are claiming.

Illness	Condition				
	When did it commence?				
Injury	How were you injured?				
	What injuries did you receive?				
	What were you doing when you were injured?				
	Where did the accident occur?				
	Details of person who witnessed the accident.	Surname	Given Name(s)		
	Address		State	Postcode	
	Telephone Number	( )			
	Did the injury occur during the course of your usual occupation?	Yes ☐ No ☐			
	If the injury resulted from a motor vehicle accident were you required to undergo a breath analysis or blood test? If Yes attach a copy of analysis result.	Yes ☐ No ☐			

2. Have you ever had this, or similar condition, in the past? Yes ☐ No ☐
If Yes, give details.

Condition			
Treated by?		Date	/ /

INJURY/ILLNESS DETAILS *(continued)*

3. Give the exact date when illness began, or injury occurred. Date / / Time am/pm

4. When did you first consult a doctor for this condition? Date / / Time am/pm

5. When did you become totally disabled (unable to work)? Date / / Time am/pm

6. If still disabled, when do you expect to return to work? Date / / Time am/pm

7. If you have returned to work, when were you able to again perform:
   - one or more of the material tasks of your occupation? Date / /
   - all the tasks of your occupation? Date / /

8. If you were admitted to a hospital, or treated as an outpatient, please give details below.

Name of Hospital	Address	From	To	In/Out Patient
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	
		/ /	/ /	

9. Details of all attending physicians.

Doctor's Name	Address	Telephone Number
		( )
		( )
		( )

10. Who is your usual family doctor?

Doctor's Name	Address	Telephone Number
		( )

How long have you been receiving treatment or advice from this doctor? years months

11. What other medical or surgical treatment has been received during the past 5 years?

Date	Nature of Treatment	Doctor's Name	Address
/ /			
/ /			
/ /			
/ /			

12. Are you now, or have you ever been, subject to or affected by any other injury, disease, deformity, defect of senses, infirmity or weakness? If Yes, give details. Yes ☐ No ☐

13. Have you ever lodged a personal accident or illness claim before? If Yes, give details. Yes ☐ No ☐

14. Are you making or entitled to make any other insurance or compensation claim in respect of this disability?
    Sick Leave Yes ☐ No ☐ Motor Compensation Yes ☐ No ☐ Other Government Benefits Yes ☐ No ☐
    Workers Compensation Yes ☐ No ☐ Private Health Fund Yes ☐ No ☐ Superannuation Life Insurance Yes ☐ No ☐
    Name of Fund(s)/Insurance Company

INJURY/ILLNESS DETAILS *(continued)*

15. Name of previous employers over last 5 years

Name of Employers	Period	
	From	To
	/ /	/ /
	/ /	/ /
	/ /	/ /

IMPORTANT: Attached is an attending physician's statement for your doctor to complete. Your claim cannot be processed until we receive your completed claim together with the attending physicians statement. We will also require medical certificates each month from the date of disablement and a final certificate showing the actual date you resumed work.

DECLARATION OF EARNINGS

IMPORTANT INFORMATION

1. If you are self-employed, Weekly Earnings means your weekly earnings derived from personal exertion after allowing for the cost and expenses in incurring that income. Please completer Section 1.
2. If you are not self-employed, Weekly Earnings means your weekly remuneration earned from personal exertion by way of salary, fees, wages, commissions and any other items already agreed by us. Please complete Section 2.
3. You may be required to supply proof of your income by submitting copies of your personal and/or business income tax returns for the full financial year immediately preceding the injury or illness for which you are now claiming.

SECTION 1 – SELF EMPLOYED PERSONS (To be completed by your accountant.)

Business /Trading Name					
Address					
		State		Postcode	

Was the business fully operational and was the Insured fully employed at the time of suffering the accident or contracting the illness? No ☐ Yes ☐ – give details

Does the business have Workers' Compensation Insurance? Yes ☐ No ☐

Please state the current weekly earnings (See Important Information 1 above.) $

Accountant's Name		Signature	

SECTION 2 – EMPLOYED PERSONS (To be completed by employer.)

Business /Trading Name					
Address					
		State		Postcode	

Please state the current weekly earnings (See Important Information 2 above.) $

Is the insured person entitled to Workers' Compensation benefits? No ☐ Yes ☐ – give details of payments

a) Weekly Rate $

b) Monies Paid to Date $

DECLARATION OF EARNINGS *(continued)*

Was the insured person in your employ at the time of suffering the injury or illness? Yes ☐ No ☐

Is the insured person entitled to receive sick leave? No ☐ Yes ☐ number of days entitled ____ days

Has the insured person received any sick leave payments in respect of the injury or illness for which he/she is claiming? No ☐ Yes ☐ number of days ____ days

Please advise the insured person's gross salary at the date of injury or illness. $ ____

Officer's Name		Position	

Telephone Number	( )	Signature		Date	/ /

PRIVACY

The QBE Privacy Promise Brochure explains what sort of personal information we collect and hold about you and what we do with that information. Please contact your Financial Services Provider to obtain a copy of the QBE Privacy Promise Brochure. A copy of the brochure may also be obtained from any QBE Commercial office or from our website at www.qbecommercial.com

DECLARATION AND AUTHORISATION BY INJURED PERSON

I hereby authorise any hospital, physician or other person who has attended me, or any employer, to furnish QBE Insurance (Australia) Limited or its representatives with any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers including verification of earnings.

I agree that a photostat copy of this authorisation shall be considered as effective and valid as the original.

I also authorise that QBE Insurance (Australia) Limited give to and obtain from any other insurers, any insurance reference bureaus and credit reporting agencies, any information relating to my insurance history as well as insurance claims information obtained during the course of this contract.

I declare that the preceding statements and information are to the best of my knowledge and belief, true in every respect.

Signature **X** ____ Date / /

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM.

QBE INSURANCE (AUSTRALIA) LIMITED
ABN 78 003 191 035

QBE Commercial

Attending Physician's Statement

Any charge for this statement must be borne by the patient.
Please complete all sections

Policy No.		Claim No.	

Important - your doctor must complete the attending physicians statement. Your claim cannot be processed until we receive your completed claim together with the attending physician's statement.

PATIENT'S DETAILS

Patient's Name	Surname					Given Name(s)			
Address					State		Postcode		
Date of Birth	/ /	Height		cm	Weight	kgs	Sex	Male ☐	Female ☐
Occupation									

HISTORY

When did the patient first receive medical treatment? Date / /

Was there a previous history of this or a similar condition? No ☐ Yes ☐ – advise when treatment was given

CONDITION

Please give a complete diagnosis of this condition.

IF INJURY

When did the patient suffer the injury? Date / / Time am/pm

What did the patient tell you were the circumstances surrounding the injury?

IF ILLNESS

When was the illness first contracted? Date / / Time am/pm

When did the symptoms become evident? Date / / Time am/pm

DEGREE OF DISABILITY

When was the patient obliged to cease work? Date / / Time am/pm

If the patient is still disabled, when will the patient be able to resume:

- one or more of the material tasks of his/her occupation? Date / /
- all of the tasks of his/her occupation? Date / /

If the patient has recovered, when was the patient able to resume:

- one or more of the material tasks of his/her occupation? Date / /
- all of the tasks of his/her occupation? Date / /

A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK.

TREATMENT OF PRESENT CONDITION

When were you first consulted? Date / /

When were you last consulted? Date / /

How often has the patient consulted you? Times

Was the patient confined to hospital? No ☐ Yes ☐ – give details

Name of Hospital	Address	Period of confinement	
		From	To
		/ /	/ /
		/ /	/ /

What are the current subjective symptoms?

Please give results of any objective findings

X Rays	
Other Tests	

What surgical procedures have been performed or are being contemplated?

Is there any underlying condition affecting recovery from the current condition? No ☐ Yes ☐ – advise nature of underlying condition and how it affects disability and recovery.

Please advise names and addresses of other treating physicians

Do you believe rehabilitation would benefit this patient? Yes ☐ No ☐

Have you terminated treatment? No ☐ Yes ☐ – advise date / /

What is the current prognosis?

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

Doctor's Name		Qualifications			
Address					
		State		Postcode	
Telephone No.	( )				

Signature X

Date / /