

# EMPLOYEE INCOME PROTECTION INSURANCE CLAIM FORM

RICHARD OLIVER  
UNDERWRITING MANAGERS

## Section 1 – Claimant Details

This section must be completed

This form is to be completed in the event of:

- An insured employee being injured, or
- An Insured Employee suffering sickness

that is covered under the company policy.

Please ensure the following sections are completed:

when completed

Section 1 :	Claimant Details	<input type="checkbox"/>
Section 1a/b:	Accident/Sickness Details	<input type="checkbox"/>
Section 1c:	Other Details	<input type="checkbox"/>
Section 2:	Authorisation & Declaration	<input type="checkbox"/>
Section 3:	Medical Practitioner Statement	<input type="checkbox"/>
Section 4:	Employers Declaration	<input type="checkbox"/>

IMPORTANT – PLEASE USE BLOCK LETTERS WHEN COMPLETING THIS FORM

Please ensure that supporting documentation is attached to the completed form. After retaining a copy of the documents for your records, all original documents should be sent direct to:

Richard Oliver Underwriting Managers Pty Ltd  
PO Box 956  
Melbourne Vic 3001

CLAIMANT DETAILS : (please print clearly)

Surname :	<input type="text"/>	Given Name:	<input type="text"/>
Date Of Birth :	<input type="text"/>	Gender:	<input type="text" value="Male"/> / <input type="text" value="Female"/>
Home Address :	<input type="text"/>		
	<input type="text"/>	State:	<input type="text"/>
		Postcode:	<input type="text"/>
Postal Address : (If different from above)	<input type="text"/>		
	<input type="text"/>	State:	<input type="text"/>
		Postcode:	<input type="text"/>
Home Phone No:	<input type="text"/>	Facsimile No:	<input type="text"/>
Mobile No:	<input type="text"/>	What is the best way for Safety Net to contact you?	<input type="text"/>
E-Mail Address:	<input type="text"/>		
What is your occupation ?	<input type="text"/>		
Who is your current employer ?	<input type="text"/>		

Should any problem be encountered or points require clarification in the completion of this claim form, please immediately contact :  
Di Hill-Shiels (03) 8681 9912 or Duncan Richardson (03) 8681 9749  
[www.roum.com.au](http://www.roum.com.au)



# EMPLOYEE INCOME PROTECTION INSURANCE CLAIM FORM

RICHARD OLIVER  
UNDERWRITING MANAGERS

## Claim Form – Section 1b:

This section to be completed if disability is due to sickness



Please attach all related medical or hospital certificates

### SICKNESS DETAILS :

1. Nature of sickness :


2. Date sickness commenced :

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3. Name of medical practitioner  
first consulted :

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Date of consultation:

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Is this your regular medical  
practitioner ?

Yes

No

Doctor's address :

--

Doctor's telephone No:

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Name, addresses & telephone  
numbers of other medical  
practitioners consulted :


4. Have you previously suffered  
the same or similar condition ?

Yes

No

If "Yes", please provide date/s of each  
occurrence

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5. Name addresses & telephone  
numbers of medical practitioners  
consulted :


Dates of previous consultations :

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Period of disability :

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Name, address & telephone no. of  
your usual medical practitioner :


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# EMPLOYEE INCOME PROTECTION INSURANCE CLAIM FORM

RICHARD OLIVER  
UNDERWRITING MANAGERS

## Claim Form – Section 1c – Other Details This section must be completed

### PERIOD OF DISABILITY :

6. Have you been wholly and continuously disabled and prevented from performing your occupation solely as a result of your condition ?  Yes  No

If "Yes"

From:

To:

7. Or, have you been partially disabled ?  Yes  No

If "Yes"

From:

To:

8. If you are still unable to perform your normal occupation, what date do you expect to return to work :

Partial Duties

Full duties

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### COMPENSATION :

9. Have you lodged a claim for compensation with any other insurance company ?  Yes  No

10. Have you lodged a claim for compensation under a workers compensation or WorkCover Act ?  Yes  No

11. Have you lodged a claim for compensation under a compulsory third party (CTP) personal injury statutory scheme ?  Yes  No

If you have answered Yes to any of the above three questions, please complete the following:

Name of company

Amount of weekly Compensation (if known)

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### OTHER INCOME :

12. Are you engaged in other work for which you receive an Income ?  Yes  No

If you have answered Yes to the above question, please complete the following:

What is/are your other occupation(s) ?

Average weekly income from other employment :

How many hours a week are you working?

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### ALTERNATIVE DUTIES:

13. If your treating medical practitioner has said you are able to perform alternative duties what activities do you think you can perform?

Claim Form – Section 2 – Authorisation & Declaration  
This section must be completed

To whom it may concern,

I authorise any hospital, physician or any other medical practitioner who has attended me or examined me to furnish Richard Oliver Underwriting Managers such details of my medical history as they may require; and

I authorise my employer to provide Richard Oliver Underwriting Managers details of my terms of employment, including details of my earnings.

I authorize Richard Oliver Underwriting Managers to release information concerning my personal and/or medical condition to third parties for the purpose of forming an opinion about my condition, my on-going rehabilitation, my return to work or the assessing validity of my claim.

I authorise Richard Oliver Underwriting Managers to release any information to my employer for the purpose of reporting in, and management of the Employee Income Protection Insurance Scheme.

I agree Richard Oliver Underwriting Managers may exchange my personal information with third parties for the purpose of assessing, or investigating my claim or my entitlement to other benefits.

A photocopy of this authority will be sufficient for you to release this information.

I declare all of the answers to questions in this Claim Form are true and correct in every detail and understand that false declarations may be punishable by law or result in my Claim being denied.

I declare that I have read the Privacy Statement below and consent to the collection, use and disclosure of my personal and sensitive information in the manner described in that Privacy Statement.

Employee 's signature : \_\_\_\_\_ Date: \_\_\_\_\_

Print name in full : \_\_\_\_\_

Witness signature : \_\_\_\_\_ Date: \_\_\_\_\_

PLEASE ENSURE ALL INFORMATION IS FULLY COMPLETED. IF REQUIRED INFORMATION IS NOT PROVIDED YOUR CLAIM FORM WILL BE RETURNED FOR COMPLETION.

COMPLAINTS – INTERNAL AND EXTERNAL COMPLAINTS PROCEDURE

If you do not agree with any decision the Insurer makes in relation to your insurance, please write to us stating what you disagree with and why. We will then either resolve or attempt to resolve your complaint immediately with the Insurer or have the matter referred to the Insurer's internal Dispute Resolution Committee (IDRC).

If you are not satisfied with a claim decision by the IDRC, the matter may be referred to an independent alternate dispute resolution body "Insurance Enquiries and Complaints Limited" provided it falls within their jurisdiction.

PRIVACY

Richard Oliver Underwriting Managers respects your privacy and complies with the Privacy Act and the National Privacy Principle. A copy of our Privacy Policy and procedures is available at our office and is available on request.

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EMPLOYEE INCOME PROTECTION  
INSURANCE CLAIM FORM

Claim Form – Section 3 – Medical Practitioner Statement (Page 1 of 2)

This section must be completed

Patient's full Name :

Date Of Birth :

Diagnosis :


(if fracture or dislocation, please describe nature and location)

If available, please attach a copy of the X-ray report

1. Does the patient have any other injury or illness that is contributing to the condition ?     Yes     No

If "Yes", please provide details :

2. Is the condition due to injury or sickness arising out of the patient's employment ?     Yes     No

If "Yes", please provide details :

3. Is the condition due to pregnancy or is pregnancy related ?     Yes     No

4. Was the disability sports related ?     Yes     No

If "Yes", please provide full details of activities – eg professional or amateur motorbike riding

5. Was the injury sustained in a race or preparation for a race ?

6. Date of onset/first symptoms of this injury/illness ?

___/___/___
___/___/___

8. When did the patient first consult you for this condition ?

9. Has the patient ever had the same or a similar condition ?

Yes     No

If "Yes", please provide details :

10. Are you the patient's usual doctor/medical practitioner ?     Yes     No

if "Yes", how long? \_\_\_\_\_ years

11. Has the patient had surgery or is it anticipated for this condition ?     Yes     No

If "Yes", please attach/provide details including date(s) and name of hospital :

12. Did you provide/arrange other medical services (including pathology) to the patient ?     Yes     No

if "Yes", please give details by itemizing and provide dates

EMPLOYEE INCOME PROTECTION  
INSURANCE CLAIM FORM

RICHARD OLIVER  
UNDERWRITING MANAGERS

Claim Form – Section 3 – Medical Practitioner Statement Cont.  
(Page 2 of 2)

This section must be completed

13. Was the patient referred by you, or to you ?

By me     to me

if "to me", please provide details :

Name and address of the  
referring doctor :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Date of referral :      \_\_\_/\_\_\_/\_\_\_

14. Is the patient still disabled? (ie unable to perform his pre-incident employment work duties) :

Yes       No

If No, what date did the patient return to work ?

\_\_\_/\_\_\_/\_\_\_

If yes, what date do you expect the patient to return to work ?

\_\_\_/\_\_\_/\_\_\_

Totally disabled (unable to perform any part of their occupation) :

from \_\_\_/\_\_\_/\_\_\_  
to \_\_\_/\_\_\_/\_\_\_

Partially disabled (unable to perform some part of their occupation)

from \_\_\_/\_\_\_/\_\_\_  
to \_\_\_/\_\_\_/\_\_\_

15. If partially disabled, please describe what duties the patient could perform and for how many hours a week ?

\_\_\_\_\_  
\_\_\_\_\_

16. Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, workers compensation insurer, social security, sports body or any other insurance body ?

Yes       No

If "Yes", please provide details :

ADDITIONAL REMARKS : (eg: Prognosis, rehabilitation program, suitability for alternative duties etc)

Prognosis:

Current Rehabilitation Program:

Suitability for Alternative Duties:

Signature of medical practitioner :

Date :

Name (print) :

Qualifications :

Address :

Telephone No :

Claim Form – Section 4 – Employers Declaration

(Page 1 of 2)

This section must be completed

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**EMPLOYER SECTION - TO BE COMPLETED BY YOUR EMPLOYER:**

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17 I advise that \_\_\_\_\_ has been unable to attend to

their usual occupation as a result of injury or sickness from \_\_\_/\_\_\_/\_\_\_ to \_\_\_/\_\_\_/\_\_\_

or continuous claim (please indicate accordingly).

His/her average gross weekly salary including commission, bonuses, overtime payments, Shift work payments, superannuation and any allowances averaged during the period of Six months (6) immediately preceding the commencement of disability or over such Shorter period as he or she has been employed and depending upon circumstances was

\$ \_\_\_\_\_ per week. (Please attach calculation)

He/she has been employed since \_\_\_/\_\_\_/\_\_\_

18 His/her occupation is

\_\_\_\_\_

His/her ordinary occupation duties are

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

19 Have you lodged a claim for compensation

(a) With any other Insurance Company Yes / No

(b) Under a Workers Compensation or WorkCover Act Yes / No

(c) Under a Compulsory Third Party Personal Injury Statutory Scheme. Yes / No

If "Yes", state –

(a) Name of Company \_\_\_\_\_

(b) Amount of weekly compensation \_\_\_\_\_

Name of Company / Organisation

Claim lodged with is \_\_\_\_\_

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EMPLOYEE INCOME PROTECTION  
INSURANCE CLAIM FORM

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Claim Form – Section 4 – Employers Declaration Cont.  
(Page 2 of 2)

This section must be completed

Division & address \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature of Paymaster \_\_\_\_\_

Name of Paymaster \_\_\_\_\_

Telephone No \_\_\_\_\_

E-mail Address \_\_\_\_\_

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PAYMENTS

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All weekly benefit payments are to be made payable and forwarded to the payroll office from which the claim was lodged providing complete weekly/period payment details.

All lump sum payments are to be forwarded direct to the employee at their home address.