EMPLOYEE INCOME PROTECTION INSURANCE

Claim Form – 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:		þ when completed
Section 1 :	Claimant Details	c
Section 1a/b:	Accident/Sickness Details	c
Section 1c:	Other Details	c
Section 2:	Authorisation & Declaration	c
Section 3:	Medical Practitioner Statement	c
Section 4:	Employers Declaration	c

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:

Safety Net Insurance Brokers
(a Division of Richard Oliver Underwriting Managers Pty Ltd)
PO Box 956
Melbourne Vic 3001

CLAIMANT DETAILS : (please print clearly)

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

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

EMPLOYEE INCOME PROTECTION INSURANCE

Claim Form – Section 1a:
This section to be completed if disability is due to an accident

Please attach all related medical or hospital certificates

ACCIDENT DETAILS :

1. Date of accident : _____ Time of accident : _____ am/pm

2. Where did the accident occur? _____

3. Were you at work at the time of injury ? c Yes c No

4. How did the accident occur & what caused it? (full description required) _____

5. Describe the injuries received _____

5a. Was an ambulance called ? c Yes c No

5b. Did the police attend ? c Yes c No (if yes, please attach a copy of their report)

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EMPLOYEE INCOME PROTECTION INSURANCE

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 :			
3. Name of medical practitioner first consulted :		Date of consultation:	
Is this your regular medical practitioner ?	c Yes c No		
Doctor's address :		Doctor's telephone No:	
Name, addresses & telephone numbers of other medical practitioners consulted :			
4. Have you previously suffered the same or similar condition ?	c Yes c No	If "Yes", please provide date/s of each occurrence	
5. Name addresses & telephone numbers of medical practitioners consulted :			
Dates of previous consultations :			
Period of disability :			
Name, address & telephone no. of your usual medical practitioner :			

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EMPLOYEE INCOME PROTECTION INSURANCE

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 ? c Yes c No

If "Yes" From: To:

7. Or, have you been partially disabled ? c Yes c 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	

COMPENSATION :

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

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

11. Have you lodged a claim for compensation under a compulsory third party (CTP) personal injury statutory scheme ? c Yes c 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)	

OTHER INCOME :

12. Are you engaged in other work for which you receive an Income ? c Yes c 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?	

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?

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EMPLOYEE INCOME PROTECTION INSURANCE

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 Safety Net Insurance such details of my medical history as they may require; and

I authorise my employer to provide Safety Net Insurance details of my terms of employment, including details of my earnings.

I authorize Safety Net Insurance 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 Safety Net Insurance to release any information to my employer for the purpose of reporting in, and management of the Employee Income Protection Insurance Scheme.

I agree Safety Net 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

Safety Net 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 – 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 ? c Yes c No

If "Yes", please provide details :

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

If "Yes", please provide details :

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

4. Was the disability sports related ? c Yes c 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 ? c Yes c No

If "Yes", please provide details :

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

if "Yes", how long? _____ years

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

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

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EMPLOYEE INCOME PROTECTION INSURANCE

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 ? c By me c 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) : c Yes c 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 ? c Yes c 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 :

EMPLOYEE INCOME PROTECTION INSURANCE

Claim Form – Section 4 – Employers Declaration
(Page 1 of 2)
This section must be completed

EMPLOYER SECTION - TO BE COMPLETED BY YOUR EMPLOYER:

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 – 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 _____

PAYMENTS

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.