Berkshire Hathaway
Specialty Insurance

Accident & Health

GROUP PERSONAL ACCIDENT INSURANCE CLAIM FORM

NOTIFICATION OF A CLAIM OR CIRCUMSTANCE THAT MAY GIVE RISE TO A CLAIM

YOUR INFORMATION

Policy Number:

Policyholder Name: ______________________________

Your Full Name: ______________________________

Full Address:

____

Date of Birth: ______________________ Sex: ☐ Male ☐ Female

Marital Status: ______________________ Number of Dependents: ______________

Telephone Mobile: ______________________ Telephone Work: ______________

Email Address: ______________________________

Policyholder Address: ______________________ Policyholder Telephone Number: ______________

Were you employed by the Policyholder at the time of suffering the Accident or contracting the Sickness? ☐ Yes ☐ No

If no, please provide further details:

ACCIDENT

Location where accident occurred: ______________________________

Date & Time of Accident: ______________________________

Please describe how the injury/accident occurred:

Please advise the extent of your injuries:

Have you previously been treated for serious injury? ☐ Yes ☐ No

If yes, please provide full details including how long you were off work:

Were there any witnesses to the accident? ☐ Yes ☐ No

Witness Name: ____

Witness Address & Contact Details:

SICKNESS

When did the sickness commence? ____

Please describe the nature of the sickness:

Have you previously been treated for this sickness or a similar type of sickness? ☐ Yes ☐ No

If yes, please provide full details including how long you were off work:

PERIOD OFF WORK

Was hospital treatment required? ☐ Yes ☐ No

If yes, complete the following regarding your hospital stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Please provide details of all attending physicians (please attach separate sheet if insufficient space)

Doctor's Name	Address	Telephone Number

Are you entitled to sick leave? ☐ Yes ☐ No

If yes, please advise number of days: ______________________________

Period you have received sick leave from ____________________ and to ____________________

When did you stop work? Date: ____________________ Time: ______________

When did you first obtain treatment from a doctor? Date: ________________________ Time: _______________

Name of treating doctor: ____

Address of treating doctor:

Is this doctor still treating you for the injury or sickness? ☐ Yes ☐ No

Is this doctor your regular doctor? ☐ Yes ☐ No
If no, please provide name & address of your regular doctor:

Is there any condition (past or present) affecting your current disability? ☐ Yes ☐ No

If yes, please provide details:

CURRENT STATUS OF DISABILITY

Are you now recovered? ☐ Yes ☐ No

*If yes, when did you return to work? (date)*____

Are you now partially disabled? ☐ Yes ☐ No

If yes, when did you return to partial duties? (date) __________________________________

Are you now totally disabled? ☐ Yes ☐ No

If no, when do you expect to return to work? (date) __________________________________

OTHER INSURANCE

Have you lodged a claim, or will you make a claim for benefits under the Accident Compensation Act (2001) that may also cover your loss? ☐ Yes ☐ No

If yes, please provide details:

CLAIMING FOR WEEKLY BENEFITS

Are you self-employed? ☐ Yes ☐ No

If yes, confirmation of earnings must be submitted with your claim form (income tax return, profit & loss statement etc.)

If you are employed as a wage earner the section below must be completed by your employer.

I hereby certify that ____ has been unable to

attend his/her usual occupation with the company as a result of an Injury/Sickness suffered whilst

____ on ____________________________________.

The employee has been incapacitated since: ____

And is expected to/did resume duties on: ____

The employee's gross salary, exclusive of bonuses, commission, allowances etc. at the date of injury/sickness was: $____________________ per week

Please specify the pay type: (sick leave, annual leave etc.) ____

If any form of pay was received, please provide full details of pay history:

Name of Company: ____

Company Address: ____

Name of Supervisor or Payroll completing this form: ____

Telephone Number: ____

Email Address: ____

____ ____

Signature of Supervisor or Payroll Date

AUTHORITY TO GIVE INFORMATION

I/we hereby authorise any doctor or medical attendant who has treated me or examined me or any person or firm who employs or has employed me to give the insurer such information as it may require regarding any injury or illness to me or my physical or mental condition or prognosis, or my employment, to assist in the proof and settlement of my claim. A photocopy of this authority can be acted upon as if it were original.

____ ____

Signature of Supervisor or Payroll Date

CERTIFICATE OF ATTENDING PHYSICIAN

To be completed by attending physician.

The claimant must obtain, at his/her own expense, the completion of this certificate from a duly qualified and registered medical practitioner. In the event of the medical practitioner being unable to answer from their own personal knowledge any of the following questions, they are requested to state so.

Furnished in connection with the disability of:

Name of Patient: ____

Full Address: ____

Are you the patient's regular physician? ☐ Yes ☐ No

If yes, how long have you known the patient? (years & months)

____

Has the patient previously suffered from the same or similar injuries/sicknesses? ☐ Yes ☐ No

If yes, provide the date and diagnosis:

Date of first consultation of this condition: ____________________

In your opinion, how long has this condition been in existence whether treated for same or not?

Present Condition:

Prognosis:

Nature of operation (if any):

Name of physician(s) who previously treated patient for the above condition:

Are the patient's symptoms:

Due exclusively to the accident? ☐ Yes ☐ No

Traceable to disease? ☐ Yes ☐ No

Infirmity or any other cause? ☐ Yes ☐ No

Is there anything in the patient's medical history which may have contributed, directly or indirect, to the injury/illness or which may be likely to retard the patients recovery? ☐ Yes ☐ No

If yes, please provide details:

Is the patient still under your care for this condition? ☐ Yes ☐ No

If no, on what date did you release the patient to perform regular duties?

____

Dates unfit for work, or unable to perform specific parts of the patient's occupation? *(if uncertain please estimate)*

____

Have you any reason to suppose that the patient was under the influence of intoxicants or drugs at the time of the accident? ☐ Yes ☐ No

If hospitalised, please provide dates: ____________________

Name of hospital: ____________________

Dates patient was totally disabled: ____________________

In your opinion, probable further disability should not exceed past the following date:

____

Name of Physician: ____________________

Full Address: ____________________

Office Phone Number: ____________________ Mobile Phone Number: ____________________

Qualifications:

____________________ ____________________

Signature of Physician Date

ELECTRONIC FUNDS TRANSFER (EFT) DETAILS:

Following approval of your claim, should you wish to have your claim transferred directly into your bank account, please provide the following details:

Name of Financial Institution: ____________________

Account Name: ____________________

Bank Code: ____________________ Account Number: ____________________

Bank Swift Code (International Payments): ____________________

Bank Account Currency (International Payments): ____________________

Bank Address (International Payments): ____________________

Please note that we are not liable for any bank processing fees incurred by you.

DECLARATION

I declare that the above statements are true and correct and that I understand that:

- this claim form may collect personal information;
- Berkshire Hathaway Specialty Insurance Company requires this information pursuant to my/our insurance policy ("the policy") and to evaluate this claim;
- the Privacy Act 1993 entitles me/us to have access to, and request correction of, any information retained;
- Berkshire Hathaway Specialty Insurance Company is authorised to collect information relevant to the policy and the claim from third parties; and
- Berkshire Hathaway Specialty Insurance Company may make our personal information available to third parties to administer this claim or when required by law to do so.

Name: ____________________ Position: ____________________

Signature: ____________________ Date: ____________________

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