



## Accident & Health

### GROUP PERSONAL ACCIDENT, JOURNEY & VOLUNTARY WORKERS 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:

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## 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:*

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## 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:*

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### 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) \_\_\_\_\_*

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### OTHER INSURANCE

Have you made, or will you make, a claim for benefits under any Workers Compensation Act or Transportation Act because of this injury?  Yes  No

*If yes, please provide details:*

	Claim Number	Name	Address/Contact Details
Employer			
Workers Compensation			
Transport Insurer			

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### 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 Claimant

\_\_\_\_\_  
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: \_\_\_\_\_

BSB: \_\_\_\_\_ 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.*

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**DECLARATION**

I hereby declare, for and on behalf of the Insured that the foregoing statements are true and correct:	
Name: _____	Position: _____
Signature: _____	Date: _____

<b>Email:</b> <a href="mailto:ahclaimsaustralia@bhspecialty.com">ahclaimsaustralia@bhspecialty.com</a>	<b>Mail:</b> Berkshire Hathaway Specialty Insurance GPO Box 650 Sydney NSW 2001
<b>Phone:</b> 1300 380 377	

## About Us

We are Berkshire Hathaway Specialty Insurance Company (ABN 84 600 643 034, AFS Licence No. 466713), authorised by the Australian Prudential Regulation Authority to carry on general insurance business in Australia.

## Privacy

We are committed to safeguarding your privacy and the confidentiality of your personal information. We, and entities acting on our behalf, only collect personal information from or about you for the purpose of assessing your application for insurance and administering your insurance policy, including managing and administering any claim made by you. Without your personal information, we may not be able to issue insurance cover, administer your insurance or process your claim.

We will only use your personal information in accordance with the *Privacy Act 1988* (Cth) and for the purposes outlined above.

We may disclose your personal information to third party service providers for the purposes outlined above or where disclosure is permitted by law. These entities may be located in Australia or overseas, including in India, Singapore, Hong Kong, the United Kingdom, New Zealand and the United States of America. Where such disclosure is made, we make all reasonable efforts to ensure that the arrangements we have in place with overseas parties impose appropriate privacy and confidentiality obligations on those parties to ensure that imparted personal information is kept secure and that such information is only used for the purposes noted above.

If you wish to obtain details of the personal information we hold about you (including contacting us to correct or update the personal information we hold about you), or if you have a complaint about a breach of your privacy, please refer to our privacy policy available at <http://www.bhspecialty.com/privacy-policy.html>, or contact our Chief Risk Officer by email to [australasia.privacy.compliance@bhspecialty.com](mailto:australasia.privacy.compliance@bhspecialty.com).

We reserve the right to refuse access under the grounds permitted by the *Privacy Act 1988* (Cth) and if you are seeking information on another person's behalf, we will require written authorisation from that individual.

## Complaints

If you have a complaint or concern about our insurance products or services we provide, please contact your intermediary or your usual BHSI contact.

If you are not satisfied with our response, you may escalate your complaint by contacting [complaints.australia@bhspecialty.com](mailto:complaints.australia@bhspecialty.com). Our internal dispute resolution process is free of charge and we will aim to respond to your escalated complaint within fifteen (15) business days.