



# Personal Accident & Illness Claim Form

THE COMPLETION OF THIS FORM AND ITS RECEIPT BY US IS NOT AN INDICATION THAT WE ACCEPT ANY LIABILITY.

PLEASE PRINT IN BLOCK LETTERS and answer all Questions  where applicable (Provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

THE FORM SHOULD BE COMPLETED AND RETURNED TO SGIO WITHIN 7 DAYS OF RECEIPT BY THE INSURED.

ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.

Claim No.

Policy No.

Expiry Date  /  /

Excess

## INSURED'S DETAILS

Name of Insured

Address

Postcode

Telephone No.  (Private)  (Mobile)  (Business)

Contact Name  Telephone No.  Facsimile No.

(1) Are you registered for GST? No  Yes

(2) What is your Australian Business Number (ABN)?

(3) What was your 'Entitlement to an Input Tax Credit' (EITC%) on your premium payment for this policy?  %

## GENERAL QUESTIONS - To be completed by the Insured

(1) What date was the Insured Person first unable to attend to their usual duties?  /  /

(2) How long has the Insured Person been disabled from engaging in or attending to their usual business as the result of the accident/illness?  
**Totally** From  /  /  To  /  /  **Partially** From  /  /  To  /  /

(3) Has the Insured Person previously suffered from a similar illness or injury? No  Yes   
**If "yes", please give details including the medical practitioners who provided advice and/or treatment.**

## INSURED PERSON'S DETAILS - To be completed by the Claimant

(1) Name <sup>Mr</sup>  <sup>Mrs</sup>  <sup>Miss</sup>  <sup>Ms</sup>   
 Address

Postcode

Age  Occupation  Telephone No.  Sex Male  Female

(2) Have you ever been affected by any illness, disease, physical defect or infirmity? No  Yes   
**If "yes", please give details.**

(3) Have you required medical or surgical treatment during the past five years? No  Yes   
**If "yes", please give details.**

(4) Are you entitled to claim from any other insurance policies in respect to this disability? No  Yes   
**If "yes", please give details.**

## ACCIDENTAL INJURY ONLY CLAIM DETAILS

(1) When did the accident happen? Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Time \_\_\_\_ am/pm  
Where did the accident happen? \_\_\_\_\_  
\_\_\_\_\_

(2) Describe fully how the accident occurred. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(3) Were there any witnesses to the accident? No  Yes   
If "yes", please give details. Name \_\_\_\_\_  
Address \_\_\_\_\_

(4) Are you employed? No  Yes

(5) Did the injury occur at work? No  Yes

(6) Describe nature of injuries sustained by the Insured Person. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(7) On what date did the Insured Person first seek medical advice/treatment for the accident? Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(8) Please give details of all your treating medical practitioners in relation to the illness. \_\_\_\_\_  
\_\_\_\_\_

## ILLNESS ONLY CLAIM DETAILS

(1) What date did the Insured Person become aware of the illness? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(2) On what date did the Insured Person **first** seek medical advice/treatment for the illness? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(3) What date was the Insured Person diagnosed as suffering from the illness? \_\_\_\_ / \_\_\_\_ / \_\_\_\_

(4) Are you employed? No  Yes

(5) Did the illness occur through work? No  Yes

(6) Describe the nature of the illness. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

(7) Please give details of all your treating medical practitioners in relation to the illness. \_\_\_\_\_  
\_\_\_\_\_

## DECLARATION AND AUTHORISATION

I/We hereby declare that the foregoing statements are true and correct. I/We consent to the Insurer, in assessing or otherwise dealing with this claim, disclosing my/our personal information to or collecting my/our personal information from related entities, other insurers, insurance reference bureaux, investigators, or other parties providing services to the Insurer.

I/We authorise any Doctor, Hospital, Clinic or other person to give to the Insurer any and all information concerning my current and/or past medical history. A photographic copy of this authorisation shall be as valid as the original.

Name \_\_\_\_\_ Name \_\_\_\_\_  
Signature \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_ Date \_\_\_\_ / \_\_\_\_ / \_\_\_\_

**NOTE: FAILURE TO HAVE THE ATTACHED CERTIFICATE OF MEDICAL PRACTITIONER COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER WILL DELAY THE PROCESSING OF YOUR CLAIM. ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.**

## DEFINITIONS

### Total Disablement

Injury or Illness which results in the claimant being entirely disabled from attending to his/her normal duties, profession, business or occupation.

### Partial Disablement

Injury or Illness which results in the claimant being restricted to only attending to part of their normal duties, profession, business or occupation.

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**PLEASE ENSURE THIS FORM IS COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER.**

**ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.**

Claim No.

Policy No.

Expiry Date

 /  / 

Excess

## MEDICAL PRACTITIONER'S DETAILS

Name <sup>Mr</sup>  <sup>Mrs</sup>  <sup>Miss</sup>  <sup>Ms</sup>

Address <sup>Other</sup>   Postcode

Qualifications

Telephone No.  Mobile No.  Facsimile No.

## CLAIMANT'S DETAILS

Name <sup>Mr</sup>  <sup>Mrs</sup>  <sup>Miss</sup>  <sup>Ms</sup>

Address  Postcode

(1) State fully the nature of the injuries or diagnosis of illness. (If an eye or limb is involved, state whether left or right)

(2) What are the current symptoms?

(3) So far as you are aware, how did the injury arise?

(4) Are the injuries sighted consistent with what was conveyed to you as the cause? No  Yes

If "no", please give details.

(5) Is the claimant suffering from any pre-existing condition which might in any way contribute, aggravate or otherwise impair the person's ability to return to their business, profession or occupation? No  Yes

If "yes", please provide details.

(6) When did the claimant first consult you in connection with the accident or illness?  /  /

(7) Has the claimant previously been treated by you for a similar illness or injury? No  Yes

If "yes", please provide details.

(8) Are you the claimant's usual Medical Practitioner? No  Yes

If "yes", how long have you known the Claimant? Years  Months

(9) Is the Claimant still under your care? No  Yes

If "yes", please provide details of the period of disablement (Refer to the Definitions).

Total From  /  /  To  /  /  Partial From  /  /  To  /  /

(10) If disablement, in whole or part, continues - how long is the incapacity likely to continue?

Total From  /  /  To  /  /  Partial From  /  /  To  /  /

(11) Any other remarks or comments.

## MEDICAL PRACTITIONER'S SIGNATURE

Name  Signature  Date  /  /

## DEFINITIONS

**Total Disablement**  
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