Claim form

Overseas Officers Insurance Policy

Accidental Death and Capital Benefits and Compassionate Travel

MUTUAL BROKERS PTY LTD
Arranged by Mutual Brokers
ABN 73 008 602 266
AFSL Number 243387

CHUBB
Policy issued by
Chubb Insurance Company of Australia Ltd
ABN 69 003 710 647
AFSL Number 239778

This form should be emailed to opi@mutualbrokers.com.au within 30 days of the accident.

Important note
The Section headed Medical Certificate is required to be completed by the attending Physician.

YOUR DETAILS

Mr ○ Mrs ○ Miss ○ Ms ○ Other

Family name

First given name

Date of birth
Date / /

Sex
○ Male ○ Female

Current address

Country

Postcode / Zip Code

Home phone number

Business phone number

Mobile phone number

Email
@

Employer's name

Were you employed at the time of suffering the accident?
○ Yes ○ No

If No, provide full details

INJURY DETAILS

Location where injury occurred

Date of injury

Date / /

Time of injury

◯ am ◯ pm

What were you doing?

How did it occur?

Nature and extent of injuries

Have you ever previously suffered from this type or a similar type of injury?

◯ Yes ◯ No

If Yes, provide full details

PERIOD OFF WORK

Give date and time of your first medical consultation for this Accident.

Date of medical consultation

Date / /

Time of medical consultation

◯ am ◯ pm

On what date did you last work?

Date / /

Have you been able, since the injury to attend in any way to your business/employment or any portion of it?

◯ Yes ◯ No

If Yes, provide full details

Have you been able to engage in any other occupation following your injury? ◯ Yes ◯ No

If Yes, provide full details

Are you now disabled?

◯ Wholly ◯ Partially ◯ Not at all

On what date did you return to work?

Date / /

If still disabled, state how much longer disability is likely to continue ?

◯ Weeks ◯ Months ◯ Permanent

Name of Medical Practitioner who attended this condition

Medical Practitioner's address

Country

Post Code / Zip Code

Name of your regular Medical Practitioner

Address of your regular Medical Practitioner

Country

Postcode / Zip Code

PREVIOUS MEDICAL HISTORY

What other medical or surgical advice, treatment or intervention have you received during the past five years? (Give dates, nature of injury and names and addresses of all doctors, hospitals and clinics). Please answer fully.

Nature of injury | Date / /

Name and address of consulting doctor, hospital or clinic

Nature of injury | Date / /

Name and address of consulting doctor, hospital or clinic

Nature of injury | Date / /

Name and address of consulting doctor, hospital or clinic

Nature of injury | Date / /

Name and address of consulting doctor, hospital or clinic

Nature of injury | Date / /

Name and address of consulting doctor, hospital or clinic

GENERAL PARTICULARS

Are you insured elsewhere for Accident? ○ Yes ○ No

If Yes, provide the insurer's details

Name of insurer

Insurer's address

Postcode

Do you hold private health Insurance? ○ Yes ○ No

If Yes, provide the insurer's details

Name of insurer

Insurer's address

Postcode

Membership Number

Have you lodged a claim under Work Cover / Workers Compensation / Compulsory Third Party Insurance or are you eligible to lodge a claim under Work Cover / Workers Compensation / Compulsory Third Party Insurance?

○ Yes ○ No

If Yes, provide the insurer's details

Name of insurer

Insurer's address

Postcode

Claim number

Status of claim

AUTHORITY TO GIVE INFORMATION (to be signed by the claimant)

I 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 Chubb such information as it may require regarding any injury 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 or xerography copy of this authority can be acted upon as if it were original.

Your Access

You have the right to access the information collected on this form

Our use of your information

We will use the information you have given us to:

1. underwrite your policy;
2. ascertain the value of your policy and things insured by it;
3. process your policy
4. respond to claims that you make and
5. assess future proposals for insurance

Disclosure of your information

We may disclose the information you have given us to the following organisations (some of which may be outside Australia);

1. re-insurers, to underwrite your policy
2. external valuers, to ascertain the value of your policy and things insured by it;
3. organisations that provide services to us in relation to the provision of insurance, to assist us in processing your policy or your claims (for example, investigators, assessors, information technology contractors and lawyers); and
4. organisations that provide services to us in relation to the management of insurance risks.

If you do not provide us with your information

We need this information to insure you and or, your property against any insurable losses and to respond to any claims you may make. If you do not give us this information we may not be able to insure you against such losses.

Our privacy policy

Please contact us if you would like information about our privacy policy.

Statement of consent

I give the information contained in this form to the Chubb Insurance Company of Australia Limited (Chubb) for any of the above purposes. I understand that this information may be disclosed to, and held by, any organisations set out above for the purposes outlined. I consent to Chubb using the information contained in this form for these purposes, and disclosing it to the organisations set out above for these purposes.

◯ I declare

Signature ✍

Date / /

Note: The issue or acceptance of this form is not to be construed as an admission of liability on the part of Chubb Insurance Company of Australia Ltd.

DECLARATION (to be signed by the claimant)

I hereby declare that I am suffering or have suffered from the injury named and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to compensation could be forfeited.

◯ I declare

Signature ✍

Date / /

PAYMENT DETAILS

Payment via EFT

Would you like to receive payments by Electronic Funds Transfer? ◯ Yes ◯ No

Please ensure the bank account details supplied are accurate to ensure you receive any payments.

Name of bank, building society or credit union

Branch where your account is held

Branch address

Postcode / Zip Code

Branch number (BSB)

			–			

Account name

Account number

Swift code (for international transfers)

Payment via cheque

Would you like to receive payments by cheque?

◯ Yes ◯ No

Name of payee

Mailing address

Country

Postcode / Zip Code

MEDICAL CERTIFICATE FROM THE ATTENDING PHYSICIAN (to be completed by the attending physician)

The claimant must obtain, at their 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

Address

Country Postcode / Zip Code

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

If Yes, how long have you known the patient?

Years Months

Diagnosis of injury

Complications

Has the patient previously suffered from the same or similar injury ◯ Yes ◯ No

If Yes, provide the date and diagnosis

Date / /

Date of first consultation for this condition

Date / /

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

Present condition

Prognosis

Nature of operation (if any)

Name of physicians who previously treated patient for the above condition

Are the patient's symptoms;

◯ due exclusively to the accident

◯ traceable to disease

◯ traceable to infirmity or any other cause?

Is there anything in the patient's medical history which may have contributed, directly or indirectly, to the injury which may hinder or delay the patient's recovery?

Is the patient still under your care for this condition?

◯ Yes ◯ No

If not, on what date did you release the patient to perform regular duties

Date / /

Dates totally unfit for work (unable to perform any part of the patient's occupation)

From / / To / /

Dates partially unfit for work (unable to perform specific parts of the patient's occupation)

From / / To / /

If uncertain, please estimate:

Totally Unfit to (date) Partially Unfit to (date)

From / / To / /

Have you any reason to believe the patient was under the influence of intoxicants or drugs at the time of the accident?

◯ Yes ◯ No

If hospitalised, give dates:

From / / To / /

Name of hospital

In your opinion, probable further disability should not exceed

◯ weeks ◯ months To / /

Name of physician

Address

Country Zip Code

Phone number

Qualifications

Signature

Date / /