Personal Accident

Claim form

GolfAustralia
Australian Golf Insurance

ZURICH

All relevant sections are to be answered in full. Please print your answers.
The company does not admit liability by the issue of this form.
It is issued to enable the insured to lodge a written statement of claim.

Claim No. (Office use only)

Type of Insurance cover

Branch
Policy No
Due date
Broker/Agent
Address

Important information

- Do not admit liability - Ask for any claim to be put in writing and refer all correspondence to ZURICH AUSTRALIAN INSURANCE LIMITED.
- Make sure you give us all the details about your claim. Attach a separate sheet if you have insufficient space on this form.
- Send all quotations you have received to repair or replace damaged property or invoices or receipts if the goods have already been repaired.

General Insurance Code or Practice

Zurich Australian Insurance Ltd is a signatory to the General Insurance Code of Practice. For more information about the General Insurance Code of Practice please go to www.zurich.com.au and select About Zurich.

Brokers please note: You can monitor the progress of a claim via Zurich Claims Online 24 Hours a Day, 7 days a week.

Privacy

Zurich is bound by the Privacy Act 1988 (Cth). Before providing us with any Personal or Sensitive Information ('Information'), you should know that:

We collect, use, process and store Personal Information and, in some cases, Sensitive Information about you such as health information, in order to comply with our legal obligations, assess your application and, if your application is successful, to administer the products or services provided to you, to enhance customer service and product options and manage a claim ('purposes').

If you do not agree to provide us with the Information, we may not be able to process your application, administer your policy or assess your claims.

By providing us or your intermediary with your Information, you consent to our use of this Information and where relevant for the purposes, you consent to our disclosure of your Personal Information, including your Sensitive Information, to your intermediary, affiliates of the Zurich Insurance Group Ltd, other insurers and reinsurers, our service providers, our business partners, medical and health practitioners, your employer, policy owners, government offices and agencies, regulators, law enforcement bodies, and as required by law within Australia or overseas. These laws include the Anti-Money Laundering and Counter-Terrorism Financing Act 2006, Personal Property Securities Act 2009, Corporations Act 2001, Insurance Contracts Act 1984, Autonomous Sanctions Act 2011, Income Tax Assessment Act 1997, Income Tax Assessment Act 1936, Income Tax Regulations 1936, Tax Administration Act 1953, Tax Administration Regulations 1976, A new Tax System (Goods and Services Tax) Act 1999 and the Australian Securities and Investments Commission Act 2001 as those laws are amended, and includes any associated regulations. From time to time other acts may require, or authorise us to collect your personal information.

Zurich may obtain Information from government offices, the parties listed above and third parties to assess applications, administer policies and assess a claim in the event of loss or damage.

For further information about Zurich's Privacy Policy, a list of service providers and business partners that we may disclose your Information to, a list of countries in which recipients of your Information are likely to be located, details of how you can access or correct the Information we hold about you or make a complaint, please refer to the Privacy link on our homepage – www.zurich.com.au, contact us by telephone on 132 687, by email at privacy.officer@zurich.com.au or by mail at 'The Privacy Officer', Zurich Financial Services Australia Limited, P. O. Box 677, North Sydney NSW 2059.

1 Insured details

Full name of Insured – Mr, Mrs, Miss, Ms

Occupation

Address State Postcode

What is your ABN What is your ITC% for this risk %

Phone number – Private Business

Policy No. Age Weight Height

Are you self employed? Yes ◯ No ◯ If 'No', please provide name and address of your employer

Name

Address State Postcode

Please indicate which of the following best describes your present occupation:-

(a) Clerical Work only ◯ (b) Performing Manual Work ◯ (c) Supervising Manual Work ◯ (d) Combination of (b) & (c) ◯

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2 Accident details

Date of accident / / Time of accident am ◯ pm ◯ Date present incapacity commenced / /

Describe exactly how the accident occurred

Nature and extent of injuries

Have you ever sustained an injury of this type in the past? Yes ◯ No ◯

If 'Yes', please provide details

Where did accident occur?

Did this accident occur at work, or on a journey to/from work? Yes ◯ No ◯ If 'Yes', are you entitled to Workers' Compensation?

Did you consume any drug or intoxicating liquor during twelve hours prior to the accident? Yes ◯ No ◯

If 'Yes', please provide specific details

3 General particulars

Can compensation be claimed from any other company or insurer? Yes ◯ No ◯

If 'Yes', please provide Name and Address of such organisation

Name

Address State Postcode

Have you been able, since the accident happened, to attend in **ANY WAY** to your business or employment? Yes ◯ No ◯

If 'Yes', please provide details

What are your average weekly earnings $ When did you first obtain medical attention? / /

Please provide Name and Address of Medical Attendant

Name

Address State Postcode

DECLARATION ON PAGE 4 TO BE SIGNED

Personal Accident

ZURICH

Medical Statement

To be furnished by the person claiming at his own expense

To be forwarded to the company within seven days. After receipt by the insured, fully completed by a duly registered medical practitioner.

1 Insured details

Name of Claimant (Patient)

Address State Postcode

Occupation

Date accident happened or illness commenced and where / /

How caused

On what date did you first attend the Claimant in consequence of present injured/illness? / /

(If the injuries sustained to a hand or an arm, a foot or a leg, state whether it is the Right or Left).

Have you reason to suspect Claimant was not sober at the time of accident? Yes ◯ No ◯ If 'Yes', please give details

How long have you known the Insured?

Are you the Claimant's regular Medical Attendant? Yes ◯ No ◯ If 'No', who is the regular medical attendant?

To your knowledge, was the Insured at the time of the accident/illness suffering from any disease or physical infirmity? Yes ◯ No ◯
If 'Yes', please provide details

Give date of last visit by the Claimant / /

Is the Claimant's incapacity due solely and directly to the accident or illness stated, independently of any other cause? Yes ◯ No ◯
If 'Yes', please provide details

Note: Temporary Total Disablement by Accident or Sickness means: that the **Patient is rendered totally unable** to engage in or attend to his usual profession, business or occupation.

Temporary Partial Disablement by Accident Only means: that the **Patient is rendered unable in material degree** to attend to or engage in his usual profession, business or occupation.

I Estimate the Claimant will be **Totally** disabled for:

weeks days

I Estimate the Claimant will be **Partially** disabled for:

weeks days

I HEREBY CERTIFY that the foregoing statements are to the best of my knowledge, information and belief, true and complete, and that I am firmly of the opinion that the stated periods of the patient's Total and/or Partial Disablement are due solely and directly to the cause or causes I have stated.

Name (Please Print)

Address State Postcode

Qualification

Signed

✗

Date

/ /

2 Declaration

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said injury or sickness shall make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover thereunder in respect of past or future injuries or sicknesses shall be forfeited.

I further agree that any Professional person, Medical Practitioner or Hospital Authority who has been or may hereafter be consulted by me relative to the injury or illness is hereby authorised and directed by me to divulge at any time to Zurich Australian Insurance Limited, their legal representatives or Loss Adjusters, any information or history they may have acquired with regard to any injury or illness.

Signed ✗ Date / /

Certificate of TOTAL Disablement

To be retained by Insured for Completion on Recovery or returned completed with claim form if recovery complete

This is to certify that I have examined Mr, Mrs, Miss, Ms

..... on / /

In my opinion he/she is/was suffering from

.....

.....

.....

He/she will be/was **totally** unfit for work from / / and up to and including / /

Qualification .....

Signed ✗ Date / /

The exact illness/injury causing the disability/incapacity **must** be stated.

Certificate of PARTIAL Disablement

This is to certify that I have examined Mr, Mrs, Miss, Ms

..... on / /

In my opinion he/she is/was suffering from

.....

.....

.....

He/she will be/was **partially** unfit for work from / / and up to and including / /

Qualification .....

Signed ✗ Date / /

The exact illness/injury causing the disability/incapacity **must** be stated.