

Injury and Sickness Benefit Claim Form



This claim form consists of 3 parts and all sections must be completed in full.

Section A Your Statement This section is to be completed by the **Person Claiming** or such authorised person.

Section B Doctor Statement Your **Treating Doctor** must complete this section and we do not hold responsibility for any charges.

Section C Employer Statement This section must be completed by your **Employer**.

Important information

1. A claim cannot be assessed until we receive at a minimum, **all sections of the completed claim form**.
2. Incomplete questions may delay the assessment process and the claim form could be sent back to be completed.
3. To have a valid claim, you must be medically disabled from work for at least the waiting period - Please refer to your policy document.
4. All **medical certificates** must be provided - Please note in order to have a valid medical certificate it must state the medical condition disabling you from work, period disabling you from returning to work and not be backdated.
5. Please ensure you have provided your Treating Doctor with a copy of your job description outlining your occupational duties.
6. Please ensure you provide to us **proof of identification** e.g. copy of your driver's licence, proof of age card etc.
7. A full **12 month wage report** prior to your disablement is required with Section C of the claim form along with your **job description** outlining your regular occupational duties.
8. All information provided must be legible.

Please return the completed Claim Form to n2n Claims Solutions

Email: info.eql@n2nclaims.com.au

Post: Locked Bag 3111, Rhodes NSW 2138

If you have any questions, please don't hesitate to contact our claims department on **1800 999 626**

Section A – Your Statement

Your Details

Given name				Surname				
Address								
Suburb			State			Postcode		
Home phone			Mobile					
Fax			Gender			Date of Birth		
Email					Height (cm)		Weight (kg)	
Who are you claiming through?	<input type="checkbox"/> Employer EBA		Name					
Do you hold Income Protection coverage through your Superannuation fund?						<input type="checkbox"/> Yes <input type="checkbox"/> No		
Superfund Name					Membership No.			
Do you have other Income Protection / Salary Continuance / Sickness and Accident Cover?						<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", provide name of Insurer								
Citizenship		<input type="checkbox"/> Australian Citizen <input type="checkbox"/> New Zealand Citizen		If other please specify				
Are you a smoker?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If "No" and you were previously a smoker, when did you cease?				
Are you a member of a Union?		<input type="checkbox"/> Yes <input type="checkbox"/> No		Name				

Employment Details				
Employer name				
Street Address				
Suburb		State		Postcode
Work phone		Work fax		
Occupation at the time of disablement			Date commenced employment	
Employment type	<input type="checkbox"/> Full-Time	<input type="checkbox"/> Part-Time	<input type="checkbox"/> Casual	<input type="checkbox"/> Contractor <input type="checkbox"/> Project Specific Work
Current work status	<input type="checkbox"/> Employed	<input type="checkbox"/> Resigned	<input type="checkbox"/> Terminated	Date Ceased
Describe your usual duties				
Do you own any part of the Business or are you Self-Employed?	<input type="checkbox"/> No	<input type="checkbox"/> Self-Employed	<input type="checkbox"/> Owner	% Owned
Do you have any other employment	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details		
Medical Details				
Is your condition an	<input type="checkbox"/> Injury OR <input type="checkbox"/> Sickness			
Description of Injury or Sickness				
If your condition is an Injury, please state exactly how, when and where it occurred. If applicable include any witness names and phone numbers.				
When did symptoms first occur for your medical condition?	Date		Time	
When did you first consult a Doctor for this medical condition?	Date			
When was your last day at work as a result of this condition?	Date			
Have you returned to work?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
• If "Yes", please provide the date you returned		• If "No", please advise the date you expect to return		
In your opinion, do you believe your condition is work related?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
In your opinion, do you believe your condition is a result of playing sports?	<input type="checkbox"/> Yes <input type="checkbox"/> No			
Is or was surgery required for your condition?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes", when was/is surgery?		
Have you had a similar condition in the past?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Details		
If you have had a similar condition in the past, please complete the details below for the physician/specialist you attended.				
DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED	

Medical Practitioner Details (Please provide a history for over 5 years)

If you've attended **more than 2 medical practitioners over the past 5 years**, please attach a list with the claim form.
Please note if a complete medical history is not provided, your claim may be delayed while we obtain a full Medicare history.

Doctors name		Practice/Hospital	
Address			
Suburb		State	Postcode
Phone number		Fax number	
Email Address			
Date first ever attended		Date last attended	Years attended
Doctors name		Practice/Hospital	
Address			
Suburb		State	Postcode
Phone number		Fax number	
Email Address			
Date first ever attended		Date last attended	Years attended

Capital Benefit (Please tick the benefit which you are claiming)

Capital Benefit Table of Benefits	
1. ACCIDENTAL DEATH of an INSURED PERSON	<input type="checkbox"/>
2a. PERMANENT TOTAL DISABLEMENT	<input type="checkbox"/>
2a. PERMANENT PARAPLEGIA /QUADRIPLÉGIA	<input type="checkbox"/>
3. PERMANENT AND INCURABLE PARALYSIS OF ALL LIMBS	<input type="checkbox"/>
4. PERMANENT TOTAL LOSS OF SIGHT OF ONE (1) OR MORE EYES	<input type="checkbox"/>
5. PERMANENT TOTAL LOSS OF USE OF ONE (1) OR MORE LIMBS	<input type="checkbox"/>
6. PERMANENT AND INCURABLE INSANITY	<input type="checkbox"/>
7a. PERMANENT TOTAL LOSS of hearing in both ears	<input type="checkbox"/>
7b. PERMANENT TOTAL LOSS of hearing in one (1) ear	<input type="checkbox"/>
8. PERMANENT TOTAL LOSS of four FINGERS and a THUMB (either HAND)	<input type="checkbox"/>
9. PERMANENT TOTAL LOSS of the lens of one (1) eye	<input type="checkbox"/>
10. PERMANENT TOTAL LOSS of use of four FINGERS of either HAND	<input type="checkbox"/>
11a. Third Degree burns and/or resultant disfigurement which covers more than 40% of the entire external body	<input type="checkbox"/>
12a. PERMANENT TOTAL LOSS of use of one THUMB both joints (either HAND)	<input type="checkbox"/>
12b. PERMANENT TOTAL LOSS of use of one THUMB one joint (either HAND)	<input type="checkbox"/>
13a. PERMANENT TOTAL LOSS of FINGERS of either HAND three (3) joints	<input type="checkbox"/>
13b. PERMANENT TOTAL LOSS of FINGERS of either HAND two (2) joints	<input type="checkbox"/>
13c. PERMANENT TOTAL LOSS of FINGERS of either HAND one (1) joint	<input type="checkbox"/>
14a. PERMANENT TOTAL LOSS of use of TOES of either FOOT - all, one FOOT	<input type="checkbox"/>
14b. PERMANENT TOTAL LOSS of use of TOES of either FOOT - great, both joints	<input type="checkbox"/>
14c. PERMANENT TOTAL LOSS of use of TOES of either FOOT - great, one joint	<input type="checkbox"/>
14d. PERMANENT TOTAL LOSS of use of TOES of either FOOT - other than great, each TOE	<input type="checkbox"/>
15. Fractured leg or Patella with established non union	<input type="checkbox"/>
16. PERMANENT shortening of leg by at least 5 cm	<input type="checkbox"/>
Broken Bone(s) Table of Benefits	
1. Neck, Or Spine (COMPLETE FRACTURE)	<input type="checkbox"/>
2. Hip, Pelvis	<input type="checkbox"/>
3. Skull, Shoulder Blade	<input type="checkbox"/>
4. Collarbone, Upper Leg	<input type="checkbox"/>
5. Upper Arm, Kneecap, Forearm, Elbow	<input type="checkbox"/>
6. Lower Leg, Jaw, Wrist, Cheek, Ankle, Hand, Foot	<input type="checkbox"/>

7.	Rib(S)	<input type="checkbox"/>
8.	FINGER(S) THUMB(S) TOE(S)	<input type="checkbox"/>

Your Bank Details (Details are required in order to process any payments, if liability is accepted)

Name of financial institution			
Name on account (e.g. John Smith)			
BSB number		Account No.	

Other Benefit Details

Have you or are you planning to lodge motor accident compensation claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or are you planning to lodge a sports insurance claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or are you planning to lodge a Workers Compensation claim?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Have you or are you planning to lodge a claim with any Government benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No
Are you making or entitled to lodge a claim with any other insurer or compensation benefit?	<input type="checkbox"/> Yes <input type="checkbox"/> No

If you have answered "Yes" to any of the above, complete the below and provide details of your claim accept decline letter, any benefit statements

Insurer/Company name			
Type of claim			
Address			
Contact person		Contact No.	
Have you or are you planning to receive any employer benefit? Sick leave etc.	<input type="checkbox"/> Yes <input type="checkbox"/> No		

Authorised Representative/s (This section is optional)

Complete this section if you **wish to authorise a family member or friend** to assist you with the claims process. It is required to allow us to disclose any personal information about your claim which includes medical, financial, employment and insurance information.

Name of authorised representative			
Representative's relationship to you		Representative's date of birth	
Representative's Phone Number		Email	

Declaration and Authorisation

Privacy Statement

In this statement “we”, “us” and “our” means the Underwriter and n2n Claims Solutions Pty Ltd as its agent and its authorised representatives.

We are bound by the obligations of the Privacy Act 1988 (Cth) and the Australian Privacy Principles. This sets out basic standards relating to the collection, use, storage and disclosure of personal information.

Our Privacy Policy, available at www.n2nclaims.com.au or by calling us on 1800 999 626 and it sets out how:

- we protect your personal information;
- you may access your personal information;
- you may correct your personal information held by us;
- you may complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint.

We, and our agents, need to collect, use and disclose your personal information in order to assess and manage any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to assess or manage a claim.

We may disclose your personal information to third parties who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers (including reinsurers) and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). Some of these parties may be located outside of Australia which includes but is not limited to the United Kingdom.

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the other parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by us by contacting n2n Claims Solutions on 1800 999 626 or via email at info@n2nclaims.com.au.

By signing this form, you consent to us and the parties mentioned below collecting, using, and disclosing personal and sensitive information about you for the purposes described above of assessing and managing your claim.

1. Parties may include: Any authorised representative of n2n Claims Solutions, my Superannuation Fund(s), my Insurance Policy Broker, my Union/ association, my authorised representatives, Employer(s) workers compensation insurer, insurance companies, government department (which includes Centrelink or similar benefit providers), claims assessor, legal firm, accountant, financial advisor, and any physician, hospital, healthcare provider who has attended or examined me, in order for n2n Claims Solutions to be supplied with my full employment, financial and medical history including but not limited to tax returns, any medical or hospital records, reports, clinical notes and referral letters.
2. I hereby declare that all information that I've supplied is true and correct in every aspect. I have not made any false or misleading statements.
3. I do understand that this claim and any future claims may be refused if any information I've provided is not true, misleading or relevant information has been withheld.
4. A photocopy, emailed or faxed version of this Declaration and Authority is considered as effective and valid as the original.

Name (please print)			
Signature		Date	

Section B – Doctor's Statement (Must be completed by your regular Treating Doctor)

Please note any and all charges for the completion of this form is the full responsibility of the patient.
It may also be helpful with the assessment and ongoing management of this claim if you can supply any additional reports, clinical notes etc.

Patient's Details

Patient's name									
Patient's address									
Suburb		State		Postcode					
Gender		Date of birth		Age					
Are you the patient's regular Doctor?		<input type="checkbox"/> Yes <input type="checkbox"/> No		How long has this patient been attending your practice/hospital?					
The medical condition currently disabling the patient from work is an				<input type="checkbox"/> Injury OR <input type="checkbox"/> Sickness					
When did the patient first attend your practice for the current condition?			Date						
What date did the patient's symptoms first appear or injuries occur?			Date						
When was the patient diagnosed?			Date						
What date was the patient incapacitated from work for this condition?			Date						
For this condition, please list all dates the patient attended your practice/hospital for treatment and advice. If insufficient space, please provide additional report									
1.		2.		3.		4.		5.	
6.		7.		8.		9.		10.	
11.		12.		13.		14.		15.	
Please state the primary medical diagnosis disabling the patient									
If any, please list all other medical conditions affecting a return to work									
What was the event / cause of the patient's current disablement?									
Please provide details of the patient's symptoms									
Please advise the prescribed medication and treatment given to the patient									
Are there any complications regarding the patient's recovery?				<input type="checkbox"/> Yes <input type="checkbox"/> No					
If "Yes", please give details									
In your professional opinion, do you believe this condition is work related?				<input type="checkbox"/> Yes <input type="checkbox"/> No					
In your professional opinion, do you believe this condition is sports related?				<input type="checkbox"/> Yes <input type="checkbox"/> No					
In regards to the patient's medical condition, have you issued any certificates or forms to any other insurance companies, workers compensation or government benefit entities?								<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", please advise to which company									

Has the patient had a similar condition in the past?		<input type="checkbox"/> Yes <input type="checkbox"/> No		If "Yes", please provide details below	
Medical condition was		Onset of the condition occurred			
DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER		DATE ATTENDED	
Has the patient been following your prescribed medication and treatment?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If "No", give details of when the patient did not follow the medical advice					
Have you advised the patient that their condition no longer requires any treatment or advice?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
If "Yes", please advise the date you gave this advice to the patient					
Has the patient been referred to a specialist for the condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
If "Yes", please give contact details					
Does the patient require surgery?		<input type="checkbox"/> Yes <input type="checkbox"/> No			
What surgery was/is required?					
If "Yes", has surgery occurred?		<input type="checkbox"/> Yes <input type="checkbox"/> No		When was/is surgery?	
If "No", surgery waiting list type		<input type="checkbox"/> Public <input type="checkbox"/> Private		Waiting list Category or Timeframe	
Have you been provided with a copy of the patient's job description outlining their occupational duties?				<input type="checkbox"/> Yes <input type="checkbox"/> No	
In your professional opinion, when do you believe the patient will be fit to return to work on alternative duties?					
In your professional opinion, when do you believe the patient will be fit to return to work for full duties?					
Please comment on the patient's current prognosis					
I certify the above patient was/is TOTALLY DISABLED from returning to work for the period				TO	
I certify the above patient was/is PARTIALLY DISABLED from returning to work for the period				TO	
Doctor's Declaration and Authority					
I hereby certify that I am a registered medical practitioner and have examined the above named patient and that all information that I've supplied is true and correct. I also acknowledge that n2n Claims Solutions may provide copies of these forms to any required representative and/or third parties deemed necessary to assist in the ongoing assessment and management of the claim.					
Practice/Hospital name					
Name (please print)					
Address					
Suburb		State		Postcode	
Phone number		Fax number			
Email					
Medical qualifications					
Signature		Date			

Section C – Employer's Statement (Must be completed by your employer paymaster/manager only)

Please ensure a **full 12 month wage report** prior to the disablement is attached with this form.
Please also ensure a **job description** outlining the employee's regular pre-disability occupational duties is attached with this form.

Employee's Details

Employee's name		Employee number	
Employee's Job Title			
Description of Injury or Sickness			
Employment type	<input type="checkbox"/> Full-Time <input type="checkbox"/> Part-Time <input type="checkbox"/> Casual <input type="checkbox"/> Contractor <input type="checkbox"/> Project Specific Work		
Current work status	<input type="checkbox"/> Employed <input type="checkbox"/> Resigned <input type="checkbox"/> Terminated		Date Ceased
Date commenced employment		Date of Injury or Sickness	
Date last actively at work		Date incapacity commenced	
Was the employee on alternative duties prior to the incapacity date?	<input type="checkbox"/> Yes <input type="checkbox"/> No If "Yes", from when?		
Expected return to work date		Employee's gross weekly earnings	\$
If the employee is fit for alternative duties are you prepared to take the employee back on alternative duties?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
In respect of this condition has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes", please advise when and to which company			
Has the employee received any employer entitlements (normal pay, sick leave, annual leave etc.) since the incapacity commenced?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
If "Yes" please complete details below and provide an additional wage report for the period			
TYPE OF EMPLOYER BENEFIT	AMOUNT RECEIVED	DATE RECEIVED FROM	DATE RECEIVED TO
	\$		
	\$		
	\$		
Do you believe the employee's condition is work related?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your company provide an EBA Income Protection policy?	<input type="checkbox"/> Yes <input type="checkbox"/> No	Insurer	
Is your company self-insured for workers compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Is the employee currently on workers compensation?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Does your company top-up workers compensation claims?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Name of Workers Compensation		Policy No.	
If employee was employed on a specific work project	Project Name		
Date commenced work on project		Completion date of project	
Estimated Employment Completion Date of Injured/ Sick Employee (Employee estimated demobilisation date?)			

Occupational Questionnaire

The following questions are in relation to your employee's regular occupation and typical duties performed.

Please advise pre-disability hours and days	
Please provide details of the environment in which they work	

