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@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?	☐ **Employer EBA**	**Name**			
Do you hold Income Protection coverage through your Superannuation fund?			☐ **Yes** ☐ **No**		
Superfund Name				**Membership No.**	
Do you have other Income Protection / Salary Continuance / Sickness and Accident Cover?			☐ **Yes** ☐ **No**		
If "Yes", provide name of Insurer					
Citizenship	☐ **Australian Citizen** ☐ **New Zealand Citizen**			**If other please specify**	
Are you a smoker?	☐ **Yes** ☐ **No**	**If "No" and you were previously a smoker, when did you cease?**			
Are you a member of a Union?	☐ **Yes** ☐ **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	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Project Specific Work				
Current work status	☐ Employed ☐ Resigned ☐ Terminated	**Date Ceased**			
Describe your usual duties					
Do you own any part of the Business or are you Self-Employed?	☐ No ☐ Self-Employed ☐ Owner	**% Owned**			
Do you have any other employment	☐ Yes ☐ No	**Details**			

Medical Details

Is your condition an	☐ Injury **OR** ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No		
In your opinion, do you believe your condition is a result of playing sports?	☐ Yes ☐ No		
Is or was surgery required for your condition?	☐ Yes ☐ No **If "Yes", when was/is surgery?**		
Have you had a similar condition in the past?	☐ Yes ☐ 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	☐
2a. PERMANENT TOTAL DISABLEMENT	☐
2a. PERMANENT PARAPLEGIA /QUADRIPLEGIA	☐
3. PERMANENT AND INCURABLE PARALYSIS OF ALL LIMBS	☐
4. PERMANENT TOTAL LOSS OF SIGHT OF ONE (1) OR MORE EYES	☐
5. PERMANENT TOTAL LOSS OF USE OF ONE (1) OR MORE LIMBS	☐
6. PERMANENT AND INCURABLE INSANITY	☐
7a. PERMANENT TOTAL LOSS of hearing in both ears	☐
7b. PERMANENT TOTAL LOSS of hearing in one (1) ear	☐
8. PERMANENT TOTAL LOSS of four FINGERS and a THUMB (either HAND)	☐
9. PERMANENT TOTAL LOSS of the lens of one (1) eye	☐
10. PERMANENT TOTAL LOSS of use of four FINGERS of either HAND	☐
11a. Third Degree burns and/or resultant disfigurement which covers more than 40% of the entire external body	☐
12a. PERMANENT TOTAL LOSS of use of one THUMB both joints (either HAND)	☐
12b. PERMANENT TOTAL LOSS of use of one THUMB one joint (either HAND)	☐
13a. PERMANENT TOTAL LOSS of FINGERS of either HAND three (3) joints	☐
13b. PERMANENT TOTAL LOSS of FINGERS of either HAND two (2) joints	☐
13c. PERMANENT TOTAL LOSS of FINGERS of either HAND one (1) joint	☐
14a. PERMANENT TOTAL LOSS of use of TOES of either FOOT - all, one FOOT	☐
14b. PERMANENT TOTAL LOSS of use of TOES of either FOOT - great, both joints	☐
14c. PERMANENT TOTAL LOSS of use of TOES of either FOOT - great, one joint	☐
14d. PERMANENT TOTAL LOSS of use of TOES of either FOOT - other than great, each TOE	☐
15. Fractured leg or Patella with established non union	☐
16. PERMANENT shortening of leg by at least 5 cm	☐
Broken Bone(s) Table of Benefits	
1. Neck, Or Spine (COMPLETE FRACTURE)	☐
2. Hip, Pelvis	☐
3. Skull, Shoulder Blade	☐
4. Collarbone, Upper Leg	☐
5. Upper Arm, Kneecap, Forearm, Elbow	☐
6. Lower Leg, Jaw, Wrist, Cheek, Ankle, Hand, Foot	☐

7.	Rib(S)	☐
8.	FINGER(S) THUMB(S) TOE(S)	☐

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?	☐ **Yes** ☐ **No**
Have you or are you planning to lodge a sports insurance claim?	☐ **Yes** ☐ **No**
Have you or are you planning to lodge a Workers Compensation claim?	☐ **Yes** ☐ **No**
Have you or are you planning to lodge a claim with any Government benefits?	☐ **Yes** ☐ **No**
Are you making or entitled to lodge a claim with any other insurer or compensation benefit?	☐ **Yes** ☐ **No**
If you have answered "Yes" to any of the above, complete the below and provide details of your claim	**e.g. 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.	☐ **Yes** ☐ **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 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. We may also use personal information, including de-identified or aggregated information where practicable, to analyse claims experience and improve our systems, processes and services. 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 or obtaining feedback on our group services.

1. **Parties may include: Any representative of n2n Claims Solutions, The Insured/Policy Owner, 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?	☐ **Yes** ☐ **No**	**How long has this patient been attending your practice/hospital?**	

The medical condition currently disabling the patient from work is an	☐ **Injury** **OR** ☐ **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?	☐ **Yes** ☐ **No**
If "Yes", please give details	
In your professional opinion, do you believe this condition is work related?	☐ **Yes** ☐ **No**
In your professional opinion, do you believe this condition is sports related?	☐ **Yes** ☐ **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?	☐ **Yes** ☐ **No**
If "Yes", please advise to which company	

Has the patient had a similar condition in the past?		☐ Yes ☐ 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?		☐ Yes ☐ 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?		☐ Yes ☐ 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?		☐ Yes ☐ No	
If "Yes", please give contact details			
Does the patient require surgery?	☐ Yes ☐ No		
What surgery was/is required?			
If "Yes", has surgery occurred?	☐ Yes ☐ No	**When was/is surgery?**	
If "No", surgery waiting list type	☐ Public ☐ Private	**Waiting list Category or Timeframe**	
Have you been provided with a copy of the patient's job description outlining their occupational duties?		☐ Yes ☐ 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	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Project Specific Work		
Current work status	☐ Employed ☐ Resigned ☐ 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?	☐ Yes ☐ 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?	☐ Yes ☐ No		
In respect of this condition has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?	☐ Yes ☐ 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? If "Yes" please complete details below and provide an additional wage report for the period	☐ Yes ☐ No		

TYPE OF EMPLOYER BENEFIT	AMOUNT RECEIVED	DATE RECEIVED FROM	DATE RECEIVED TO
	$		
	$		
	$		

Do you believe the employee's condition is work related?	☐ Yes ☐ No		
Does your company provide an EBA Income Protection policy?	☐ Yes ☐ No	**Insurer**	
Is your company self-insured for workers compensation?	☐ Yes ☐ No		
Is the employee currently on workers compensation?	☐ Yes ☐ No		
Does your company top-up workers compensation claims?	☐ Yes ☐ 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	

Are there any special skills, qualifications or licences required to perform their current occupation? Please specify	

What are the usual duties for their pre-disability position (e.g. supervisory duties, office duties, driving, essential physical i.e. lifting >10kg, etc.)

Usual Duties	Frequency (% of job)	Comments

Employer's Declaration and Authority

I am authorised to complete this form on behalf of the employer and all information 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.

Company name					
Paymaster/Manager name		**Job title**			
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax No.**			
Email					
Signature		**Date**			