

**RMIT claims must be submitted via the RMIT Insurance Team at the following address: [insurance@rmit.edu.au](mailto:insurance@rmit.edu.au)**

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## ACCIDENT & HEALTH INTERNATIONAL

# Claim Form

### PERSONAL ACCIDENT &/OR SICKNESS

#### IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. Please note that Sections 1, 2, 5, 7 & 8 are compulsory.
3. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by Accident & Health International Underwriting Pty Limited.

#### SECTION ONE: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

Policy Number	Expiry Date		
<input type="text"/>	<input type="text"/>		
Name of Insurance Broker (if known)	Name of Insured Company		
<input type="text"/>	<input type="text"/>		
Title	Given Name(s)	Gender	
<input type="text"/>	<input type="text"/>	<input type="checkbox"/> M <input type="checkbox"/> F	
Family Name	Date of Birth		
<input type="text"/>	<input type="text"/>		
Residential Address	Suburb	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email Address	Daytime Contact Number	Alternative Number	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Occupation, Trade or Profession	Usual Duties		
<input type="text"/>	<input type="text"/>		

#### SECTION TWO: PAYMENT DETAILS - COMPULSORY

Please tick preferred method of Payment for refund.

<input type="checkbox"/> Cheque	Payee		
	<input type="text"/>		
<input type="checkbox"/> Direct/EFT Payment	Account Holder's Name		
	<input type="text"/>		
BSB Number	(6-Digits)	Account Number	Bank
<input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>

**SECTION THREE: DETAILS OF ACCIDENT - COMPLETE IF AS A RESULT OF AN ACCIDENT**

Date of Accident

Time

AM / PM

Address where accident occurred:

Were there any witnesses to the accident?

Yes  No

Witness Name:

Witness Address:

Please describe how the accident / injury occurred:

What were the injuries?

Have you previously been treated for any serious injury?

Yes  No

If Yes, please give details:

Give details of any previous claim made for any previous injury against any insurance company: (please attach separate sheet if insufficient)

**SECTION FOUR: TO BE COMPLETED IF DISABILITY IS AS A RESULT OF AN ILLNESS / SICKNESS**

The nature of illness:

When did the illness begin?

Have you had this complaint before?

Yes  No

If Yes, how long were you disabled?

Days  Months  Years

## SECTION FIVE: TREATMENT - COMPULSORY

Was hospital treatment required?  Yes  No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

When did you stop work? Time AM / PM

When did you first obtain treatment from doctor? Time AM / PM

Name of Doctor  Address

Is this doctor still treating you for the injury / illness?  Yes  No

Is this doctor your regular doctor? (If No, please give details)  Yes  No

Name of Regular Doctor  Address

Is there any condition (past or present) affecting your current disability?  Yes  No

If Yes, please give details

Are you now:

Recovered	<input type="checkbox"/> Yes <input type="checkbox"/> No	When did you return to work?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Partially Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	When did you return to work undertaking part of	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>
Totally Disabled	<input type="checkbox"/> Yes <input type="checkbox"/> No	When do you expect to return to work?	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>

Have you made, or will you make, a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury?  Yes  No

If Yes, please give details

	Claim Number (if known)	Name	Address
<b>Employer</b>			
<b>Workers Comp / Transport Insurer</b>			

Are you entitled to claim benefits for this Injury / Illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government?  Yes  No

If Yes, please give details

Name	Address

**SECTION SIX: TO BE COMPLETED ONLY IF CLAIMING FOR LOSS OF INCOME**

**WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME**

**1. IF SELF EMPLOYED PLEASE INDICATE BY TICKING THE BOX**

Confirmation of earnings **MUST** be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

**2. IF EMPLOYED AS A WAGE EARNER TO BE COMPLETED BY YOUR EMPLOYER**

I hereby certify that  has been unable to attend his/her usual occupation with the company as a result of an Injury / Illness suffered whilst  on the   
He/She has been incapacitated since  and is expected to/did resume duties on   
His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was \$  per week.  
During the period of incapacity he/she received: \$  from  to   
Please specify type of pay

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

Name of Company  Has been employed since

Address

Signature of Supervisor or Paymaster  Date

Name (Please Print)  Telephone Number

**SECTION SEVEN: DECLARATION - COMPULSORY**

**Dispute Resolution Statement**

Accident & Health International Underwriting Pty Ltd is an agent for our insurers who are signatories to the General Insurance Code of Practice developed by the Insurance Council of Australia.

If you have a dispute and after talking to Accident & Health International Underwriting Pty Ltd, you are still dissatisfied and you wish to take the matter further we have a Complaints and Dispute Resolution Procedure which undertakes to provide an answer to your concerns within fifteen (15) working days.

If you are not satisfied with our dispute resolution process, we will advise you on how to contact the insurance industry's external independent complaints scheme.

Access to the Dispute Resolution scheme is free of charge to you.

**By signing and dating the form above or returning this form electronically, once completed, you declare the following:**

**Declaration:**

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I/We agree that, by submitting this form, the personal information I/We provide to Accident & Health International Underwriting Pty Ltd in this form or otherwise may be collected, held, used and disclosed in the manner set out in our [Privacy Policy](#) including for the processing of this claim.

**Authority**

I authorise any hospital and/or physician who has treated me to provide Accident & Health International with copies of medical records or of my past medical history, as requested.

Signature of Claimant

Date

Signature of the Insured (if other than claimant)

Date

# ACCIDENT & HEALTH INTERNATIONAL MEDICAL CERTIFICATE

**Sydney**  
 Level 4, 33 York Street  
 Sydney NSW 2000  
 GPO Box 4213, Sydney,  
 NSW, 2001  
 T: +61 2 9251 8700  
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[www.acchealth.com.au](http://www.acchealth.com.au)



THE CLAIMANT MUST OBTAIN AT OWN EXPENSE FROM THE PATIENT'S USUAL DOCTOR IN ALL CASES

**IMPORTANT: THE MEDICAL ATTENDANT IS RESPECTFULLY REQUESTED TO GIVE AS MUCH DETAIL AS POSSIBLE IN ORDER TO ASSIST OUR CLIENT AND AVOID THE NECESSITY OF ADDITIONAL ENQUIRES**

## SECTION EIGHT: PATIENT DETAILS - COMPULSORY

Full Name  Date of Birth

Please give complete diagnosis of this condition

### HISTORY

When did the patient first receive medical treatment?

Is there a previous history of this or a similar condition?  Yes  No

If Yes, please provide details

How long have you known the patient?  Days  Months  Years

Are you the regular general practitioner?  Yes  No If not, please advise who is

### SICKNESS

When was sickness first contracted?

When did symptoms become evident?

### INJURY

When did the patient first suffer the injury?

OR

What was the cause of the injury?

### DEGREE OF DISABILITY

When was patient obliged to cease work?  
 Date

When was / will the patient be / able to return to:  
 Some Duties?   
 Full Duties?

### TREATMENT OF PRESENT CONDITION

When were you consulted?

Was patient confined to hospital?  Yes  No  
 From   
 To

If Yes, please advise name and address of hospital

What other surgical or medical procedures are possibly contemplated?

Are there any underlying conditions affecting recovery from the current conditions?  Yes  No

If Yes, could you advise the nature of underlying conditions and how they affect disability and recovery

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Print Name:  Qualification:  Signature:   
 Address:  Phone:   
 Fax:  Date: