COMBINED INSURANCE

A division of Chubb Insurance Australia Limited

Combined Insurance Claim Form

Important Instructions on How to Complete the Attached Claim Form and How We Assess Claims

Please read these important instructions on how to complete the attached Claim Form. This may help us to assess your claim faster.

We refer to the Insured or Covered Person as "you" or "your"; and Combined Insurance a division of Chubb Insurance Australia Limited as "Combined Insurance", "we", "our" or "us", in the following instructions.

1. You should complete Section 1 in full. If you do not fully complete the Claim Form this may result in delays processing your claim while we seek missing information. Please see the Important Notes for Particular Benefits.
2. Your Medical Practitioner, *and only your Medical Practitioner* should complete Section 2 in full. Your Medical Practitioner must also sign and date the Claim Form in the appropriate place.
3. We normally pay benefits up to the date that your Medical Practitioner has signed the Claim Form. If your disability is ongoing after that date, we will send you a Continuing Claim Form or Progress Form which your Medical Practitioner should sign and complete on your next visit. Once we have received this completed form, we can make a further payment up to the date your Medical Practitioner has signed the form. The reason we do not pay benefits in advance of when your Medical Practitioner signs a Claim Form, is that the future disability has not yet occurred, and insurance only pays for losses that have already occurred. We follow this procedure even if your Medical Practitioner states an "approximate date" for your disability to end. Of course, all payments depend on your claim falling within the terms and conditions of your Policy.
4. We may ask you or your Medical Practitioner for more information concerning your claim, or we may arrange a further independent assessment by a Specialist of our choosing.
5. **Please forward this Claim Form within 30 days of the commencement of your disability, to Combined Insurance, PO Box 403, North Sydney, NSW 2059**. If you do not report your claim within 30 days and we consider the delay has prejudiced our ability to assess your claim, this may affect and/or delay payment of your claim.
6. Should you require any assistance in completing this Claim Form, or have any queries about claiming, or how we assess a claim, please contact us on **1300 300 480** and we will be happy to assist you.

Important Notes for Particular Benefits

7. If your Policy covers you for benefits while you are **hospitalised**, please attach a copy of your hospital statement showing the dates of admission and discharge.
8. If you were not hospitalised, but, your Policy covers you for continuous confinement to bed under the full time care of a Registered Nurse or Professional Carer, please attach a statement from the Registered Nurse or Professional Carer indicating the dates of full time care.
9. If you are claiming for **Covered Cancer** please attach a copy of a Pathology, Histology, or Histopathology Report, that medically verifies the diagnosis.
10. If you are claiming a benefit for **Skin Cancer**, please attach a medical statement verifying this.
11. If you are claiming a **Transportation** benefit please attach a receipt for your travel expenses.
12. If you are claiming a **Family Lodging** benefit please attach a copy of your hotel/motel bill.
13. If you are claiming a **Facial Disfigurement** benefit, please send a photograph of the relevant scar with your claim form. Please note that we may require you to submit a further photograph of your scar if your injury had not fully healed at the time you first lodged your claim.
14. If you have been claiming the insurance premiums as a **Tax deduction**, you are obliged by law to report your ABN number on the Claim Form.

Combined Insurance Claim Form - Section 1

Claimant to Complete this Page *(Please print using BLOCK LETTERS)*

☐☐☐☐☐☐☐ *Office Use Only*

Important. **Write your Account Number here** ☐☐☐☐☐☐☐☐☐

Claimant's Full Name ☐Mr ☐Mrs ☐Ms

Residential Address State Postcode

Postal Address *(If different from above)* State Postcode

Claimant's Telephone Number *(Daytime)* ( )

Claimant's Mobile Number

Claimant's Email Address

Date of Birth / / Height Weight

Occupation Employer's Contact Person

Employer's Contact Telephone Number ( )

Employer's Address

Please write your ABN here if you are claiming input tax credits for GST on your premiums / / /

Are you claiming under a Family Policy? ☐Yes ☐No Account Number

It is our preference to make claims payments by Electronic Funds Transfer.

Do you want us to make payments on this claim by EFT into your account ☐Yes ☐No

If *Yes,* is the account that you pay your premium from the Account you want us to pay your claim payments to ☐Yes ☐No

If *No,* please provide the following:

Name of Financial Institution Account Name

BSB Number Account Number

Complete for Accident only

1. When did the accident occur? Date / / at am/pm
2. Where did the accident occur? Street

   Suburb State
3. Nature of Injuries *(Please be specific)*
4. How did the accident occur? *(Please be specific)*

5. If a motor vehicle accident, please provide a description of the vehicle(s) involved.
   (Note: if more than 2 vehicles involved attached details of other vehicles separately.)

   Your Vehicle: Rego Make and Model

   The other person: Rego Make and Model
6. Was the accident reported to the Police? ☐Yes ☐No Date / / Police Station

   Was anyone charged by the Police? ☐Yes ☐No If *Yes,* who was charged?

   What was the charge? *(Note – You must provide us with a copy of the Police Report if we request you to)*
7. During the 24 hours before the accident, did you drink any alcohol or take any drugs? ☐Yes ☐No *Give details*
   State types & quantities

   Did you have a BAC or Drug Test by the Police? ☐Yes ☐No If *Yes* what was the result?
8. Were you transported to Hospital by Ambulance after the accident? ☐Yes ☐No
   Name of Hospital you attended. *(Note: You must provide us with a copy of the Ambulance Report if we request you to)*
9. Eye witness details. Please provide details of any eye witness.

   Witness 1 Name Address

   Email Address

   Telephone Number *(Business hours)* ( ) Mobile Number

   Witness 2: Name Address

   Email Mobile/Bus. Hours Number

   Witness 3: Name Address

   Email Mobile/Bus. Hours Number

Complete for Sickness only

10. Nature of sickness *(Please be specific)*

11. When were the symptoms first noticed? Date / /

12. Who was the first Medical Practitioner you consulted for this condition?

Medical Practitioner's Name

Address

Telephone Number ( )

When did you first see the Medical Practitioner for this condition? / /

13. Have you consulted any other Medical Practitioner for this condition? ☐ Yes ☐ No *Give details*

Medical Practitioner's Name

Address

Telephone Number ( )

Dates of Consultations

14. Did you go to Hospital in respect of this sickness? ☐ Yes ☐ No *Give details*

Hospital Name

Address

Date of Admission / / Date of Discharge / / Number of Days in Hospital

15. Have you previously had the same sickness? ☐ Yes ☐ No *Give details*

Date(s)

Treatment Received

Name of treating Medical Practitioner/Specialist

Addresses of Medical Practitioner/Specialist who treated you

Complete for Accident and Sickness

16. Which Medical Practitioner is currently treating you for your injury/illness? *(if the same as Q12 write "as above")*

Medical Practitioner's Name

Address

Telephone Number ( )

When did you first see the Medical Practitioner for this condition? / /

Other Dates of Treatment?

17. Who is your usual family Medical Practitioner? *(If the same as Q16 write "as above")*

Name

Address

Telephone Number ( )

18. What other significant medical or surgical treatments have you received in the past 5 years? *Give details*

Date(s)

Nature of the condition(s) treated

Name of treating Medical Practitioner/Specialists

Addresses of Medical Practitioner/Specialist who treated you

19. Are you affected by any other long term or chronic disability? ☐ Yes ☐ No *Give details*

20. Were you hospitalised or continuously confined to bed under the continual care and attention of a Registered Nurse or Professional Carer as required by your Medical Practitioner? If yes, please state the dates. ☐ Yes ☐ No

From / / to / /

Please attach a copy of any hospital statements if you are hospitalised and claiming a confinement benefit.

21. Transport and Family Lodging Benefits. In some instances you may claim for Transportation and/or Family Lodging Benefits. Please attach receipts supporting your claim if you are claiming for these. ☐ Yes ☐ No

22. If you are claiming a benefit as the result of the diagnosis of any covered Skin Cancer, please attach medical proof. ☐ Yes ☐ No

23. "Total Disability". Between what dates were you unable to perform any duties? *(Refer to the definition at the top of Section 2)*

From / / to / /

24. "Partial Disability". Between what dates were you able to perform only partial duties? *(Refer to the definition at the top of Section 2)*

From / / to / /

25. Date you returned to your normal duties. Date / /

Combined Insurance Claim Form - Section 2

Medical Practitioner only to complete this section

This section must be fully completed by a Legally Qualified Medical Practitioner, at the Claimant's expense..

Definitions *(Please read carefully before completing this section)*

Total Disability:	The inability to perform each of the substantial duties of your business or occupation (usual activities if not employed).
Partial Disability:	The inability to perform one or more, but not all of the substantial duties of your business or occupation (usual activities if not employed).
Medical Practitioner:	Means a licenced medical practitioner operating within the scope of his or her licence and who is not a member of your immediate family.

Patient's Name Date of Birth / /

1. Please tick whether claim is for: ☐ Sickness ☐ Injury
   Diagnosis

   Cause

2. If the patient is suffering from an injury, how did the patient advise you that the injury occurred?

3. **Please Complete for Fractures only.** Was the Fracture confirmed by an X-Ray? ☐ Yes ☐ No *Please attach a copy of the x-ray report*
   Describe the type of Fracture

4. When did the symptoms first appear, or the accident happen? Date / /

5. When did the patient first consult you for this condition? Date / /
   a) Did total disability begin this day? ☐ Yes ☐ No b) If *No*, please state date disability started. Date / /

6. Has the patient ever had this condition before? ☐ Yes ☐ No
   If *Yes* please state if the present condition is an aggravation or recurrence of a previous injury or sickness.
   Recovery Date / /

7. Has the patient ever had any other disease or infirmity that may be affecting the present condition? ☐ Yes ☐ No
   If *Yes*, what was the disease or infirmity?
   To what degree did this contribute to current disability?

8. Is the patient still under your care for this condition? ☐ Yes ☐ No
   If *No* and the patient has recovered, please write the recovery date. Recovery Date / /
   If *Yes*, and the patient has not recovered, what is the expected recovery date? Please provide details of the Treatment Plan to assist the patient's recovery.

9. Has the patient had surgery or is surgery anticipated? ☐ Yes ☐ No Date / /
   Details of surgery

10. Has the patient been referred to any other Medical Practitioner or Specialist? ☐ Yes ☐ No – If *Yes* please provide details
    Medical Practitioner's Name
    Address
    Telephone Number ( ) Date referred / /

11. Are you the patient's usual Treating Medical Practitioner? ☐ Yes ☐ No If *Yes*, for how many years?
    If *No*, please advise the details of the patient's usual Treating Medical Practitioner/Medical Practice.
    Name
    Address
    Telephone Number ( )

12. Disability Periods. (Please refer to definitions at top of page)

a) Totally Disabled From / / to / / *(inclusive)*

b) Partially Disabled From / / to / / *(inclusive)*

c) Hospitalised as a resident in-patient. From / / to / / *(inclusive)*

At *(Name of Hospital)*

d) Continuously confined to bed and requiring the full time care of a Registered Nurse or Professional Carer

From / / to / / *(inclusive)*

Name of Professional Carer:

e) Do you expect the patient to remain totally disabled for the next 12 months? ☐ Yes ☐ No

13. Is there any further medical information relevant to this claim?

Medical Practitioner's Stamp (Required)

Signed X

Print Name

Date / / Provider Number

Qualifications

Address *(if not on stamp)*

Telephone Number *(if not on stamp)* ( )

Email Address *(if not on stamp)*

(We recommend that a copy of this form is taken for your files)

COMBINED INSURANCE®

A division of Chubb Insurance Australia Limited

Chubb Insurance Australia Limited ABN 23 001 642 020 | AFSL Number 239687

Combined Insurance is a division of Chubb Insurance Australia Limited

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30001 - 11/16

Combined Insurance a division of Chubb Insurance Australia Limited
Claim Privacy Consent, Medical Authority and Declaration

Claim Privacy Consent

Combined Insurance a division of Chubb Insurance Australia Limited (Chubb) is committed to protecting your privacy. Chubb collects, uses and handles your personal information only in accordance with the Privacy Act 1988 (Cth) (Privacy Act). A copy of our Privacy Policy is available on our website at www.combined.com.au or by contacting our customer relations team on 1300 300 480.

Your personal information will be used by Chubb, or any third party that Chubb provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:

(a) any information provided in relation to your claim;
(b) any information that is health information or sensitive information, including, without limitation, your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
(c) any other personal information that you may provide to Chubb or its third party contractors;
(d) any information relating to any insurance policy on your life, including terms and conditions and claims history;
(e) details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
(f) any other information relating to your income, assets, liabilities and solvency; and
(g) any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To assess and process your claim Chubb may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example, social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant or investigator retained by Chubb, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

Chubb may disclose your personal information, including health and sensitive information, to other entities within the Chubb Group, other insurers, our reinsurers or third parties, including contractors and contracted service providers (such as assessors or investigators) who we, or those other Chubb Group entities, have engaged to provide a specific service. Those entities may be located overseas, for example the regional head offices of Chubb in Singapore, UK or USA or third parties with whom we or those other Chubb Group entities have subcontracted to provide a specific service for us, which may be located outside of Australia (such as in the Philippines or USA).

Chubb may also disclose your personal information to witnesses in respect to your claim and to government agencies including the police (where we are compelled to by law).

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, Chubb may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1300 300 480 or email customer@combined.com.au.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, Chubb has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Chubb using and disclosing my personal information pursuant to Chubb's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Chubb's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to Chubb such personal information (including health information) as Chubb in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and co-operation to Chubb in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim. I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint Chubb to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of the Claimant

Date / /

Name of Claimant

Signature of the Witness

Date / /

Name of Witness