



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 Claimant as “You” or “Your”; and Combined as “Combined”, “We”, “Our” or “Us”, in the following instructions.

1. You should complete Section 1 in full. Please see the important notes below.
2. Your Doctor, **and only your Doctor** should complete Section 2 in full. Your Doctor must also sign and date the Claim Form in the appropriate place.
3. We normally pay benefits up to the date that your Doctor has signed the Claim Form. If your disability is ongoing after that date, we will send you a Progress Form which your Doctor should sign and complete on your next visit. Once we have received this completed Progress Form, we can make a further payment up to the date your Doctor has signed the form. The reason we do not pay benefits in advance of when your Doctor signs a Claim or Progress 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 Doctor 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 Doctor 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 (not a copy) within 30 days of the commencement of your disability, to Combined Insurance, PO Box 403, North Sydney, NSW 2059.** If you do not do this within 30 days, we may have a problem in paying 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 are claiming for **Malignant Cancer** under a Cancer or Critical Illness Policy, please attach a copy of a Pathology, Histology, or Histopathology Report, that medically verifies the diagnosis of Malignant Cancer.
9. If you are claiming a benefit for the medical removal of a lesion or non-malignant **Skin Cancer**, please attach a medical statement verifying this.
10. If you are claiming a **Transportation** benefit under your Cancer Policy, please attach a receipt for your travel expenses.
11. If you are claiming a **Family Lodging** benefit under your Cancer Policy, please attach a copy of your hotel/motel bill.
12. 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.
13. If you are claiming a **Facial Disfiguration** benefit, please send a photograph of the relevant scar with your Claim Form.

If You Want to Complain

You have access to Combined's free Dispute Resolution Process that relates to any aspect of our business, including claims handling, or any problems you have experienced in dealing with our staff or Representatives. The steps you can take are outlined below.

STEP 1 If you're not happy, we want to know!!

Please let us know immediately if you have a problem. Making a complaint is the first and often the only step you will need to take in the Dispute Resolution Process.

Phone, write, fax, or email our Customer Service Centre at Head Office and let us know of your complaint. It is important that you provide all the necessary details and the reasons why you are unhappy, so that we can attempt to find a solution that suits everyone.

If we cannot finalise your complaint immediately, we will aim to do so within 15 business days. (Additional time may be required where the complaint involves a Representative of our Company).

We would prefer that your complaint is put in writing.

Mail: The Complaints Officer
Combined Insurance Company of Australia
PO Box 403, North Sydney NSW 2059

Fax: (02) 9922 2096
Please mark your fax – Att: The Complaints Officer.

Email: customer@combined.com.au
Att: The Complaints Officer.

Telephone: Toll Free: 1300 300 480
Local Area: (02) 9922 5033
Call our Customer Service Centre and speak to our Customer Service Operators.

STEP 2 Internal Dispute Resolution

If you are dissatisfied with our response to your complaint, please let our Disputes Officer know.

Outline your concerns and explain the reasons why you feel that we should review the original decision. **Or ask our Customer Service Centre to refer your dispute to our Disputes Officer.**

Our Disputes Officer has the authority to review the original decision, ensuring that correct procedures

were followed, and is obliged to be fair and timely in investigating the dispute. In most cases, you will receive a reply within 15 business days from our receipt of your dispute.

We would prefer that your dispute is put in writing.

Mail: Disputes Officer
Combined Insurance Company of Australia
PO Box 403, North Sydney NSW 2059

Fax: (02) 9922 3386
Please mark your fax – Att: The Disputes Officer.

Email: customer@combined.com.au
Att: The Disputes Officer.

Telephone: Toll Free: 1300 300 480
Local Area: (02) 9922 5033

STEP 3 External Dispute Resolution

If you are still dissatisfied, the following options are available:

If you are unhappy with our internal dispute resolution (IDR) decision you may refer your dispute to the Insurance Ombudsman Service (IOS). The IOS provides a free and independent dispute resolution service for consumers who have general insurance disputes that are covered by its Terms of Reference. If you wish your dispute to be reviewed by IOS you must refer your dispute to IOS within three calendar months of receiving the IDR decision and you can do this by contacting IOS at:

Mail: The Insurance Ombudsman Service
PO Box 561
Collins Street West, Melbourne, VIC 8007

Tel: 1300 78 08 08 (National toll free)
(03) 9613 6300

Fax: (03) 9621 2060

Email: ios@insuranceombudsman.com.au
Website: www.insuranceombudsman.com.au

Privacy: At Combined we are committed to ensuring that we handle your personal information in accordance with the National Privacy Principles and the Privacy Act.

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

Postal Address State Postcode

Residential Address (If different from above) State Postcode

Occupation Employer's Name

Date of Birth / / Height Weight

Employer's Address

Claimant's Telephone Number (Daytime) ()

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

Complete for Accident only

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

2. Nature of Injuries (Please be specific)

3. How did the accident occur? (Please be specific)

4. If a motor vehicle accident, please provide a description of the vehicle(s) involved.

5. Was the accident reported to the police? Yes No Date / / Police Station

6. Eye witness details. Please provide details of any eye witness.

Name Address

Complete for Sickness only

7. Nature of Sickness (Please be specific)

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

9. Have you previously had the same sickness? Yes No When?

Doctor's name and address.

Complete for Accident and Sickness

10. Were you hospitalised or continuously confined to bed under the continual care and attention of a registered nurse as required by your doctor? If yes, please state the dates. Yes No From / / to / /
Please attach a copy of any hospital statements if you are claiming a confinement benefit.

11. **Cancer Policy (Transport and Family Lodging Benefits).** In some instances under a Cancer Policy you may claim for Transportation and/or Family Lodging Benefits. Please attach receipts supporting your claim if you are claiming for these. Yes No

12. **Skin Cancer Benefit.** If you are claiming a benefit as the result of the removal of a non-malignant Skin Cancer, please attach medical proof. Yes No

13. Attending doctor's name and address. Dates of treatment / / / /
Name Address

14. "Total Disability". Between what dates were you unable to perform any duties? (Refer to the definition on the reverse of this form)
From / / to / /

15. "Partial Disability". Between what dates were you able to perform only partial duties? (Refer to the definition on the reverse of this form.)
From / / to / /

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

17. a) Authorisation to release information

I authorise any hospital, doctor, medically related facility, insurance company or employer to release to Combined Insurance Company of Australia, ("Combined"), any information concerning my health for the purpose of processing this claim.

b) Declaration

I solemnly declare the above answers to be true and correct in every detail, and that I have not withheld any material information in relation to the above claim.

c) Claimant's Signature

(If Minor, Parent's Signature) X

Date / /

Combined Insurance Claim Form - Section 2

Doctor only to complete this page

This page must be fully completed by a Legally Qualified Doctor, at no expense to Combined.

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).

Doctor: 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 *(Describe complications if any)*

2. *Please Complete for Fractures only.* Was the Fracture confirmed by an X-Ray? Yes No

Describe the type of Fracture.

3. Were the injuries sustained in a MVA, Motorcycle, Tractor or Aircraft Accident? Yes No

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

5. When did 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 / /

9. Disability Periods.

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) *(Total and Permanent Disability only)* Has the Insured, as a result of the injury, been totally or permanently disabled continuously for the past 12 months? Yes No Will the Insured remain totally and permanently disabled? Yes No

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

Doctor's Stamp

Signed X _____

Date / / Degree _____

Address *(if not on stamp)* _____

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