360
Accident & Health

Personal Accident and Sickness Claim Form

360 Accident & Health Pty Ltd **ABN** 25 623 247 978 is an Authorised Representative (**AR** 1262596) of
360 Underwriting Solutions Pty Ltd **ABN** 18 120 261 270, **AFSL** 319181
Level 18, 201 Kent Street, Sydney, NSW 2000

360 Personal Accident and Sickness Claim Form

How to Fill in the Claim Form

- Please complete the sections regarding your illness or injury in full, otherwise the processing of your claim cannot proceed.
- Ensure you sign the Privacy Declaration.
- Ensure that **your employer** completes the relevant section in full.
- Ensure **your doctor** completes the "Medical Practitioners Statement To Company" in full.
- Attach a copy of your most recent Payslip to your claim submission.
- Scan and email the claim form through to claims@360uw.com.au. The completion of this form does not constitute policy acceptance by the insurer.
- Failure to notify a matter immediately after the event or after you become aware of the event may enable the insurer to reduce or avoid any liability incurred.
- This Claim Form should be completed in full and honestly. Please sign and return it to your Broker as soon as possible with any relevant photos and attachments.
- If insufficient space is provided, please attach separate sheet(s) and sign and date each sheet attached.
- Incomplete, illegible or unclear answers will delay processing of your claim.
- To ensure prompt action, please submit ALL documentation submitted to claims@360uw.com.au

General Insurance Code of Practice

In accordance with our binding authorities, where we act on behalf of the insurer, we are bound by the General Insurance Code of Practice. The Code is designed to set minimum standards of practice and service in the insurance industry.

Further information about the Code can be obtained from www.codeofpractice.com.au

Agent of Insurer

In accordance with the requirements of the *Corporations Act* 2001, 360 Accident & Health in arranging or effecting this insurance or dealing with or settling claims will be acting under an authority given to it by certain insurers. Accordingly, 360 Accident & Health will be acting as an agent of the insurers and not an agent of the insured.

Complaints and Dispute Resolution

We view seriously any complaint made about our products or services and will deal with it promptly and fairly.

If you have a complaint please first try to resolve it by contacting the relevant member of our staff.

If the matter is still not resolved, please then contact our Internal Disputes Resolution Officer on 1800 411 580 or by email at idr@360uw.com.au or by writing to us at the address for 360 Accident & Health Pty Ltd given in this form. They will seek to resolve the matter in accordance with the General Insurance Code of Practice and our Dispute Resolution procedures.

If the matter is still not resolved, or you are not satisfied with the way a complaint has been dealt with we will provide you with information about Lloyd's Australia and the Australian Financial Complaints Authority (AFCA) including their contact information.

Privacy Statement

We are committed to protecting your privacy in accordance
We are committed to protecting your privacy in accordance with the *Privacy Act 1988 (Cth)* and the Australian Privacy Principles (APPs), which will ensure the privacy and security of your personal information.

The information provided in this document and any other documents provided to us will be dealt with in accordance with our Privacy Policy. By executing this document you consent to collection, use and disclosure of your personal information in accordance with our Privacy Policy. If you do not provide the personal information requested or consent to its use and disclosure in accordance with our Privacy Policy, your application for insurance may not be accepted, we may not be able to administer your services/products, or you may be in breach of your duty of disclosure.

Our Privacy Policy explains how we collect, use, disclose and handle your personal information including transfer overseas and provision to necessary third parties as well as your rights to access and correct your personal information and make a complaint for any breach of the APPs.

A copy of our Privacy Policy is located on our website at www.360uw.com.au

Please access and read this policy. If you have any queries about how we handle your personal information or would prefer to have a copy of our Privacy Policy mailed to you, please ask us.

If you wish to access your file please ask us.

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Policy/Claimant Details

Employer name

Policy No.

Title

Given Name(s)

Gender

Family name

Date of Birth

Residential Address

State

Postcode

Do you consent to us communicating with you by email? Yes No

Email Address (important)

Daytime Contact Number

Alternative Number

Occupation, Trade or Profession

Work Site / Location

For what are you claiming? Weekly Benefit Capital Benefit Non Medicare Medical Expenses (If applicable)

Insurance Broker

Name of your Insurance Broker

Address

City

State

Postcode

Contact Name

Telephone

Mobile

Fax

Email

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Details of Injury - complete if as a result of 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 from a similar or same 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)

During the 24 hours before the injury, did you drink any alcohol or take any drugs? Yes No

If Yes, please state types & quantities

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, when

and how long were you disabled?

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Treatment Received

Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

When did you stop work? Date Time AM PM

When did you first obtain treatment? Date Time AM PM

Name of Current Treating Doctor

Clinic Name/ Address

Name of Regular Doctor

Clinic Name/ Address

Date Doctor was first consulted

Date Doctor was last consulted

How long have you known this Doctor? YEARS MONTHS

If you have not seen the above Doctor for more than 5 years or have visited other than this Doctor, please provide the Doctor's information for the past 5 years. If this is not completed, it may delay your claim.

Name of Doctor (1)

Clinic Name/ Address

Date Doctor was first consulted

Date Doctor was last consulted

How long have you known this Doctor? YEARS MONTHS

Name of Doctor (2)

Clinic Name/ Address

Date Doctor was first consulted

Date Doctor was last consulted

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How long have you known this Doctor? YEARS MONTHS

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

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

If Yes, please give details

Are you now

Recovered Yes No When did you return to work?

Partially Disabled Yes No When did you return to work undertaking part of?

Totally Disabled Yes No When do you expect to return to work?

Have you made, or will you make, or are you entitled to 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
Employer			
Workers Comp / Transport Insurer			

Name of your Superfund

Superfund Membership No.

Are you entitled to Income Protection Benefits through your Superfund? Yes No

If yes, have you made a claim? Yes No

Claim Reference Number

Are you entitled to claim benefits for this Injury / Illness from other Insurers (i.e. Personal Income Protection Insurance), Persons, Company, Health Fund, Friendly Society or Government? Yes No

If Yes, please give details

Name	Address

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To be Completed by your Employer

We are unable to process benefit payments without confirmation of income

If self employed please submit confirmation of earning (i.e. Income Tax Return & Profit/Loss Statement)

Employer's Name

This is to Certify that

has been unable to attend his/her occupation as a result of Injury or Sickness

From

Until

His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was AUD $

Please attach the employee's pay history for the 12 months prior to their last day at work

Employee's Occupation

Type of Employment ☐ Permanent Full Time ☐ Permanent Part Time ☐ Casual ☐ Fixed Term/Contract

Are they still employed ☐ Yes ☐ No

If no, please provide the last date they were employed

His / Her sick leave entitlement as at the date of injury or illness
Days

He/She has been employed since
Date

Has a claim for Worker's Compensation been lodged ☐ Yes ☐ No

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission/CTP? ☐ Yes ☐ No

Signature of Supervisor or Manager

Name Of Supervisor Or Manager (Please Print)

Telephone Number

Dated

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Medical Practitioner's Statement to Company

The claimant is responsible for any fee for this statement. This form should be FULLY completed and returned promptly

Patient's Name

DOB | Height | Weight

Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound)

Cause

Is this condition ☐ an injury ☐ an illness

Does the patient have any other injury or illness that is contributing to the condition? ☐ Yes ☐ No

Provide Details

Is the condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Provide Details

Was the disability sports related? ☐ Yes ☐ No

Provide Details

Date of onset/first symptoms

When did the patient first consult you for this condition?

Has the patient ever had the same or similiar condition? ☐ Yes ☐ No

If yes, from when & diagnosis

Name of patient's usual doctor/medical practice

How long have you been the patient's usual doctor/medical practice?

If the patient been hospitalised please provide

Admission Date

Discharge Date

Name of Hospital

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Has the patient had surgery or is it anticipated? Yes No

Provide Details

Date performed or anticipated

Name of hospital

Please outline all treatment received to date in the management of your patient's condition.
Please include any relevant medical documents, reports or investigative scans.

Was the patient referred by you or to you? Yes No

Provide Details

Doctor's details

Date of referral

Is the patient still disabled?

No when did the patient return to work?

Yes how long will the patient be:

totally disabled (unable to perform any part of their occupation) from / to

partially disabled (able to perform part of their occupation)

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body? Yes No

Name of Company/Contact/Claim Number

Signature of medical practitioner

Date

Name + Qualifications (print)

Address

Telephone

Electronic Funds Transfer Details

Following 360 Accident & Health's approval of your claim, your claim benefits can be transferred directly into your bank account. Please provide the following details:

Name of Financial Institution

Account Name

BSB

Account No

Bank SWIFT code (if required)

Bank Address

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, 360 Accident & Health Pty Ltd (360 A&H) and its agent has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to 360 A&H and its agent using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, the underwriting agent, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to 360 A&H'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 360 A&H's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to 360 A&H and its agent such personal information (including health information) as 360 A&H and its agent 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 cooperation to 360 A&H and its agent 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 if I do not consent to the terms of this authority or revoke my consent, 360 A&H and its agent may not be able to process or assess my claim.

I appoint 360 A&H and its agent 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 Insured

Date

Print Name

Signature of Witness

Date

Print Name

Date of preparation: 1 November 2018
Effective date: 1 November 2018

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NSW

Level 18, 201 Kent St
Sydney, NSW 2000

The Forum, Level 3
240 Pacific Highway
Charlestown, NSW 2290

VIC

Level 9, 99 William St
Melbourne, VIC 3000

QLD

Level 8, 500 Queen St
Brisbane, QLD 4000

SA

PO Box 1166
Nairne, SA 5252