Claim form for sickness and injury benefit

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Please return to one of the following:

Address: **GPO Box 1276 Sydney 2001** Email: **Membercare.claims@qbe.com** Freecall: **1800 226 122** Fax: **02 9295 5554**

Checklist

Prior to forwarding your claim to the address above, please ensure you have:

- Answered all the questions
- Signed and dated the claim form
- Had your attending Doctor complete the relevant section
- Completed all declarations on page 4

Please be advised that we will be unable to assess your claim if all requested information is not provided.

Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint. When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our **Privacy Policy** at **www.qbe.com.au/privacy**, or to obtain a copy by phoning us on **133 723** or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Personal details

Full name Mr/Mrs/Miss/Ms/Other	Surname		Given name(s)	
Date of birth *(dd/mm/yyyy)*				
Address				
		State		Postcode
Complete telephone No.	( )	Policy No.		
Name of financial institution		Membership No.		

Insured's statement

This claim form only asks you for information that is necessary for us to assess your claim. All questions must be answered or delays in the assessment of your claim may result.

Loan details

Current policy No.	Loan No.		Repayment amount $	

Do you have an insured line of credit or an overdraft? Yes No

Employment details

Occupation at time of disability		Length of time in that occupation		Years
Hours worked per week	Hours	Name of employer		
Employer's telephone No.	( )			

Medical details

Name of your usual doctor				
Address of your usual doctor			Postcode	
Telephone No.	( )	How long have they been your doctor:		Years

If fewer than 12 months please give names, addresses, telephone numbers and dates of all the doctors consulted in the past 5 years: (please attach extra page if required)

Name		Telephone No.		
Address			Postcode	
Attended from *(dd/mm/yyyy)*		to *(dd/mm/yyyy*		

Disability details

When did you last work?	(dd/mm/yyyy)		When did you first attend a doctor this time?	(dd/mm/yyyy)	
When did you go back to work?	(dd/mm/yyyy)		When do you expect to go back to work?	(dd/mm/yyyy)	

Are you claiming disability benefit under any other insurance? Yes No

Have you submitted a claim for workers compensation or are you intending to do so? Yes No

If 'yes', please give the name and telephone number of the company and person dealing with the claim

Name		Telephone No.	( )

Complete this section if claiming for an accident

Please describe how and where the accident happened:

Date of accident	(dd/mm/yyyy)		Time of accident		am pm

Injuries sustained

Complete this section if claiming for a sickness

Please describe the circumstances of the sickness which prevents you from working, including the history of the condition over the past 5 years (if any):

Have you suffered from a similar problem(s) previously? Yes No

If 'yes', how often did you consult your doctor? Weekly Monthly Other (please explain below)

Please give details of previous consultations below (If there is not room for all information, please attach a separate document)

Consultation date (dd/mm/yyyy)	Time off work		Name and address of doctors/hospitals etc
	From (dd/mm/yyyy)	To (dd/mm/yyyy)	

Doctor's statement

Attending doctor's statement (Doctor only to complete entire section)

Mr/Mrs/Miss/Ms/Other			
is/was prevented from working as (nature of employment)			
Diagnosis		Date they were first treated (dd/mm/yyyy)	
Cause as stated to you by patient		Time they were first treated	am pm

If there is more than one condition, please specify which condition is predominantly preventing the patient from performing their usual occupation:

And is/was therefore unable to work (date disability commenced)		(dd/mm/yyyy)	
to (date disability ended) (dd/mm/yyyy)		to (anticipated date of recovery) (dd/mm/yyyy)	

If you are unable to estimate the date of recovery, do you believe the period of disability will last

less than three months three to six months more than six months

Is the patient fit to perform alternative duties?	Yes No	If 'yes', from what date? (dd/mm/yyyy)	
Do you need to see the patient again?	Yes No	If 'yes', when? (dd/mm/yyyy)	
Is this patient claiming worker's compensation for this disability?	Yes No		

The treatment recommended is/was	
The prognosis is	

Are there any other medical conditions which may have a bearing on the current disability?	Yes No
If 'yes', please describe	
Would you say that any of the above are primary contributions to the current disability?	Yes No
If 'yes', what conditions and why?	
Have they received medical diagnosis, treatment or attention previously for this or a similar disability or related cause?	Yes No
Have further consultations been necessary since then?	Yes No
If 'yes', please give details of frequency of consultation and/or dates	

Please give the name and address of first treating doctor			
Name			
Address		Postcode	

Give names and addresses of all other doctors attended or specialists to whom referred, with relevant dates			
Name		Telephone No.	
Address		Postcode	
Date of attendance *(dd/mm/yyyy)*			
Name		Telephone No.	
Address		Postcode	
Date of attendance *(dd/mm/yyyy)*			

Are you their regular doctor?	Yes No	If 'yes', how long?	years
Name			
Address		Postcode	
Telephone No.			
Signature **X**		Date of attendance *(dd/mm/yyyy)*	

Declaration and authority

1. I agree that all costs incurred in obtaining evidence in relation to my claim (including the cost of obtaining information from any doctor, hospital or employer) will be at my own expense.
2. I declare that the statements and particulars supplied by me on this form are true and correct (including those not in my own handwriting) and that I have not withheld any information relevant to this claim. I understand that I will not receive any payment if my claim is fraudulent.

Insured's name:			
Signature		Date *(dd/mm/yyyy)*	

Medical authority

I authorise any doctor, hospital or clinic to provide QBE Life (Australia) Limited ABN 83 089 981 073 AFSL 245492 and QBE with all information and copies of documents regarding my medical history including details of medical conditions, treatment, prognosis, tests, x-rays or ultrasounds and any reports from other doctors, hospitals or clinics. A photocopy of this authority is deemed to be as effective as the original.

Insured's name			
Signature		Date *(dd/mm/yyyy)*	

Employer authority

I authorise my employer (or former employer) to provide QBE Life (Australia) Limited ABN 83 089 981 073 AFSL 245492 and QBE with all information and copies of documents regarding my employment and any sickness or injury I have suffered. A photocopy of this authority is deemed to be as effective as the original.

Insured's name			
Signature		Date *(dd/mm/yyyy)*	