PRORISK
PROBLEM SOLVED

PERSONAL INJURY CLAIM FORM

Level 1, 2 Wellington Parade, East Melbourne. 3002.
ph: 03 9235 5255 fax: 1800 633 073
email: enquiries@prorisk.com.au
web: www.prorisk.com.au

Professional Risk Underwriting Pty Ltd ABN 80 103 953 073. AFSL 308076.

PRORISK PERSONAL INJURY CLAIM FORM

Name:
Number:

Important Information

1. Please complete the Policy Details Section and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully
3. To avoid delay in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
4. Claims may be subject to an excess as described in your Policy.
5. Please send this form and all documentation to: ProRisk, PO Box 542 East Melbourne, Vic 8002.

A. POLICY AND CLAIMANT DETAILS COMPLETE FOR ALL CLAIMS

Name of Policy Holder: _____

Name of Insured Person

Surname: _____ Given Names: _____

Policy/Certificate Number: _____ Expiry Date: / /

Name of the Broker who provided the cover: _____

Title: _____ Surname: _____ Given Names: _____

Home Address: _____ State: _____ Postcode: _____

Postal Address (if different from above): _____ State: _____ Postcode: _____

Private Phone: _____ Business: _____ Mobile: _____

Email: _____

Employer's Name: _____

Occupation: _____

Usual Duties: _____ Date of Birth: / /

What are you gross weekly earnings:$ _____

Who are you claiming for: ☐ Self ☐ Spouse/Partner ☐ Child Given Name: _____

What are you claiming for? (e.g Temporary Total Disablement): _____

Electronic Funds Transfer Details

Following ProRisk approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

Name of the Financial Institution: _____ Account Name: _____

BSB Number: _____ Account Number: _____

GST Information (For Australian Claims Only)

Are you registered for GST Purposes? : ☐ Yes ☐ No

What is your Australian Business Number (ABN)?: _____

Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? : ☐ Yes ☐ No

If YES, what percentage of the GST did you claim or are you entitled to claim? % (if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%): _____

B. POLICY AND CLAIMANT DETAILS COMPLETE FOR ALL CLAIMS

What is the injury or illness?: _____

If injury, how exactly did it occur? (i.e playing sport, etc): _____

When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed?: / /

Did the injury or illness cause you to stop work? : ☐ Yes ☐ No When?: / /

Have you returned to work full-time? : ☐ Yes ☐ No When?: / /

OR

Have you returned to work part-time? : ☐ Yes ☐ No When?: / /

If YES, what hours and duties are you working?: Days: _____ Hours: _____

Duties: _____

Is this condition due to injury or sickness arising out of your employment? : ☐ Yes ☐ No

If Injury, how exactly did it occur?: _____

_____

Who is your usual family doctor?

Title: _____ Surname: _____ Given Names: _____

Address: _____ State: _____ Postcode: _____

Phone: _____

When did you first get treatment from a medical practitioner for this condition?

Doctor's Name: _____

Address: _____ State: _____ Postcode: _____

Phone: _____

When did you first see the medical practitioner?: / /

Have you consulted any other medical practitioner for this condition? : ☐ Yes ☐ No

Doctor's Name: _____

Address: _____ State: _____ Postcode: _____

Phone: _____

Period: / /

Did you go to hospital?: ☐ Yes ☐ No

Hospital Name: _____

Address: _____ State: _____ Postcode: _____

Date of Admission & Discharge: / / Number of Days in Hospital: _____

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

State types & quantities: _____

Have you ever had this or a similar condition in the past?: ☐ Yes ☐ No

Date(s): _____

Treatment received: _____

Name of treating Doctors/Specialists: _____

Address: _____ State: _____ Postcode: _____

What other significant medical or surgical treatment have you received in the past 5 years?

Date(s): _____

Nature of the condition(s) treated: _____

Name of treating Doctors/Specialists: _____

Address of Doctors/Specialist who treated you: _____

State: _____ Postcode: _____

Are you affected by any other long term or chronic disability: ☐ Yes ☐ No

Provide details: _____

C. CLAIMS FOR ADDITIONAL BENEFITS FOR INJURY OR ILLNESS

Not all policies provide these benefits. Please only complete if applicable

Are you claiming for:

- homecare or income replacement after major surgery for cancer
- childminding or income replacement after a child's accident
- home tuition fees after a child's accident
- medical expenses not covered by Medicare
- damage to personal property

Give details, specifying each item

Item Amount

_____ $ _____

_____ $ _____

_____ $ _____

_____ $ _____

Please attach invoices or other evidence of the expenses you have incurred or receipts for Damaged property.

D. OTHER INSURANCE / BENEFITS

Are you claiming insurance or compensation from any other insurance company? eg. Workers Compensation, Traffic Accident Commission, sports body or any income replacement. ☐ Yes ☐ No

Provide details: _____

Name of insured organisation/employer: _____

Phone insured organisation/employer: _____

Type of cover: _____

Amount claimed per week: _____ Do you have private health insurance? ☐ Yes ☐ No

Do you have ambulance cover? ☐ Yes ☐ No

E. TO BE COMPLETED BY YOUR EMPLOYER

If Self Employed please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earnings.

Name of Employer: _____

This is to certify that:_____ of _____

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

His/Her average Gross Weekly Salary at the time of this accident/sickness was: $_____ per week

He/She has been employed since: / /

His/Her Sick Leave Entitlement at the time of this accident/sickness was: _____

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? ☐ Yes ☐ No

Signature of Employer or Supervisor: _____

Name of Employer or Supervisor (please print): _____

Telephone Number: _____ Date: / /

PRIVACY CONSENT - CLAIM ASSESSMENT

Protection of My Privacy
Acknowledgement and Consents

Professional Risk Underwriting Pty Ltd (ProRisk) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principles.

A copy of our Privacy Policy is available on our website at www.prorisk.com.au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by ProRisk, or any third party that ProRisk 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:

- Any information provided in relation to your claim;
- 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;
- Any other personal information that you may provide to ProRisk or its third party contractors;
- Any information relating to any insurance policy on your life, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- Any other information relating to your income, assets, liabilities and solvency; and
- 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 process your claim ProRisk 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 retained by ProRisk 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').

ProRisk may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other companies in the ProRisk group, other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. ProRisk may also disclose your personal information to witnesses in respect to your claim.

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, ProRisk 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 03 9235 5255 or email enquiries@prorisk.com.au.

MEDICAL AUTHORITY, DECLARATION AND POWER OF ATTORNEY

I declare that,

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

I agree to ProRisk using and disclosing my personal information pursuant to ProRisk'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 ProRisk's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to ProRisk such personal information (including health information) as ProRisk 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 ProRisk 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 ProRisk 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 Claimant: _____ **Date:** _____

Name of Claimant: _____

Signature of Witness: _____ **Date:** _____

Name of Witness: _____

MEDICAL PRACTITIONER'S STATEMENT TO COMPANY

The policyholder is responsible for any fee for this statement this form should be completed and returned to ProRisk promptly.

Patient's Full Name: _____

Date of birth: / / Height:_____ cms Weight: _____ kgs

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

_____

_____

If available please provide a copy of X-Ray report

Is this a condition: ☐ an injury ☐ or an illness

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

If YES, give details: _____

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

If YES, give details: _____

Was the disability, sports related? ☐ Yes ☐ No

If YES, give details: _____

Date of onset/first symptoms?: / / When did the patient first consult you for this condition?: / /

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

If YES, give details: _____

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

Has the patient been hospitalised

Date of Admission: / / Date of Discharge: / /

Name of Hospital: _____

Name of patient's usual doctor/medical practice: _____

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

If YES, give details: _____

Date performed or anticipated: / / Give name of hospital? _____

Did you provide other medical services (including pathology) to the patient?: ☐ Yes ☐ No

If YES, give details

Date: / / _____

Date: / / _____

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

If YES, please provide name and address of referring doctor:

Name: _____

Address: _____ State: _____ Postcode:_____

Date of referral: / /

Is the patient still disabled?: ☐ Yes ☐ No

If NO, when did the patient return to work?: / /

If 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)

From: / / To: / /

If partially disabled, what duties could the patient perform and for how many hours a week?:_____

_____

_____

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

If YES, give details: _____

Name of Company and Claim No: _____

Contact Name and Telephone No.: _____

Remarks: _____

_____

_____

Signature of medical practitioner: _____

Name: _____ **Date:** _____

Qualifications: _____

Address:_____ **State:** _____ **Postcode:** _____

Phone: _____