MAKE A DISABLEMENT CLAIM

THANK YOU FOR CONTACTING CGU INSURANCE

You must have access to a printer in order to access this form. If you do not have access to a printer please contact our office on 1800 248 224 (1800 CGU CCI) and one will be sent.

HOW TO COMPLETE YOUR DISABLEMENT CLAIM FORM

Your claim form must be completed in full. An incomplete form may cause delay in the assessment of the claim.

Please ensure:

- you (the insured) complete pages one (1) and two (2) of your disablement claim form
- that you (the insured) and a witness have both signed and dated your claim form
- your treating Doctor completes pages three (3) and four (4) of your claim form
- if the date you last worked or the date your injury or illness first occurred is more than three (3) months ago, a letter is attached to your claim form detailing the reason(s) for the late lodgement of your claim.

Other useful information

If you have submitted your claim form and it has been accepted by CGU Insurance, we will require you to provide current medical certificate(s) from your Doctor in order for us to maintain continuous payments to your financier. Your medical certificate(s) can be for a maximum period of three (3) months from the date noted on the certificate(s) and must state your exact disability.

PLEASE NOTE, MEDICAL CERTIFICATES THAT STATE "MEDICAL CONDITION" ARE NOT ACCEPTABLE.

Please advise us on 1800 248 224 (1800 CGU CCI) if you return to any form of employment during the period you are claiming for.

It is important that all questions are correctly and fully answered by the policy holder. This will enable CGU Insurance to proceed with the processing of your claim; delays could occur if the claim is completed by someone other than the policy holder or if insufficient information is supplied. If for some reason the policy holder is unable to complete this form, please contact the office to discuss options.

Third person authority to enquire

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the attached authorisation and return with your completed claim form.

Please send all completed claim forms to one of the following:

FAX 1800 032 535
EMAIL cciclaims@cgu.com.au
POST GPO Box 2177 Melbourne VIC 3001

CCI0041 REV7 07/19

GPO BOX 2177 Melbourne VIC 3001
T 1800 CGU CCI (1800 248 224)
F 1800 032 535
E cciclaims@cgu.com.au

Insurer
Insurance Australia Limited
ABN 11 000 016 722 AFSL 227681
trading as CGU Insurance

DISABLEMENT CLAIM FORM

Insurance Australia Limited ABN 11 000 016 722 trading as CGU Insurance

All questions must be answered. Please print and indicate ✓ where applicable. If insufficient space provided, please write on a separate sheet and attach to the form.

Your personal details

Title | Name of Insured Person | Date of birth (D D / M M / Y Y)

Address | Postcode

Telephone number | Email

Name of financier | Date policy commenced (D D / M M / Y Y) | Monthly Instalments ($) | Loan BSB | Loan account No.

Occupation at time of disability | Your usual occupation

Current employer (or previous employer) | Date employed from (D D / M M / Y Y) | Date employed to (D D / M M / Y Y)

Address | Postcode | Telephone number

Are you claiming Workers' Compensation? No ☐ Yes ☐ ▶ State Insurer | Claim No.

Address | Postcode | Telephone number

Name and date of birth of any other person listed on policy

Your disability details

Date on which the illness or injury first occurred (D D / M M / Y Y) | Time (AM/PM) | Your last working day (D D / M M / Y Y)

Describe the circumstances leading to your current disability

Who is your usual doctor? | For how long? Years | Months

Your doctor's address | Postcode | Telephone number

Doctor at policy commencement date | Address | Postcode

Please state the names and addresses of all other doctors and hospitals consulted for this current disability

Name

Telephone number

Address

Postcode

Name

Telephone number

Address

Postcode

Was injury caused by motor vehicle accident?

No Yes ▶ if so did police attend? No Yes ▶ Event No.

When did you resume work duties? OR When do you expect to be fit for some work duties?

D D / M M / Y Y D D / M M / Y Y

Your medical history

1. Have you previously suffered from this injury or illness or any similar injury or illness?

No Yes ▶ Name of doctor Date of consultation (1) Date of consultation (2)

D D / M M / Y Y D D / M M / Y Y

▶ Address Postcode Telephone number

▶ Reason for consult Period of disability (from) Period of disability (to)

D D / M M / Y Y D D / M M / Y Y

2. Have you previously suffered any other major illness/injury unrelated to this disability?

No Yes ▶ Please provide details of complaint

▶ Date of occurrence Period of disability (Yrs/Mths/Days)

D D / M M / Y Y Years Months Days

3. Do you take regular medication for any illness or injury?

No Yes ▶ Please provide details of medication and condition

Claims history

Have you ever submitted any previous claims for injury or illness?

No Yes ▶ Please provide details (including reference number)

Name of company Telephone number Date

D D / M M / Y Y

Declaration

I have never had a Life, Trauma, Involuntary unemployment, Sickness or Accident policy cancelled, declined or accepted on special terms.

No ☐ Yes ☐

I hereby declare that:

1. I am the person insured by this policy and referred to in the foregoing particulars.
2. The above statements and answers are correct and true and I acknowledge responsibility for their completeness and accuracy, whether the answers have been written by me or by any other person on my behalf.
3. I am fully aware and agree that any false statements and particulars made by me on this form or any further declarations will result in my claim being denied.
4. I authorise any hospital, institution or medical practitioner who has treated or examined me or any person or firm who has employed me, or any firm through which I have claimed compensation to provide CGU Insurance or their agents any information it may request in respect of any trauma, illness, injury, medical history, treatment or advice received by me. A photocopy of this authority can be acted upon as if it were the original.
5. I authorise the creditor to provide CGU Insurance with details of my loan for administration of this claim.
6. I/we agree that, by submitting this form, the personal information I/we provide to CGU Insurance in this form or otherwise may be collected, held, used and disclosed in the manner set out in the CGU Privacy Policy found at www.cgu.com.au/privacy, including for processing this claim.
7. I understand that I may contact CGU Insurance if I wish to update or access my personal information.

Signature of insured	Print name	Date
		D D / M M / Y Y

Signature of witness	Print name	Date
		D D / M M / Y Y

CGU Insurance is a member of the insurance industry's independent Australian Financial Complaints Authority (AFCA). This Service is provided to the public at no cost and aims to resolve claims complaints quickly and informally if CGU Insurance is unable to resolve your complaint. You should first take your complaint up with CGU. In most cases, the problem will be resolved easily. If you are not satisfied with the outcome you may contact the Australian Financial Complaints Authority in your state for advice and assistance in resolving your claim.

THIRD PERSON AUTHORITY TO MAKE AND RECEIVE CLAIMS ENQUIRIES IN RELATION TO MY CLAIM

If you wish to provide authority for another person to discuss your claim on your behalf, please complete the following authorisation and return with your completed claim form.

I, _____ (name)

of _____ (address),

freely give permission for:

Name: _____

Address: _____

Contact Ph. No: _____

To contact and be contacted by CGU Insurance to discuss information relating to and about my Trauma claim.

I know that I may request a copy of this authorisation. I agree that a copy of this authorisation shall be as valid as the original.

I understand that this authorisation shall be valid until my claim is processed and finalised, and that I have a right to revoke this authorisation by written notification to CGU Insurance.

Signed by _____

Print name _____ Dated _____

Witness signature _____

Print name _____ Dated _____

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Insurer
Insurance Australia Limited
ABN 11 000 016 722 AFSL 227681
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MEDICAL CERTIFICATE

Insurance Australia Limited ABN 11 000 016 722 trading as CGU Insurance

All questions must be answered. Please print and indicate ✓ where applicable. If insufficient space provided, please write on a separate sheet and attach to the form.

Important note

This certificate must be completed by the qualified and registered Medical Practitioner treating you for your current condition. In the event of the medical practitioner being unable to answer, from personal knowledge, any of the following questions, this must be stated.

This Certificate is to be completed at the insured's expense and forwarded by the Medical Practitioner to CGU Insurance at the earliest opportunity.

Doctor's details

Name of attending doctor

Telephone number

Insured's name

Date of birth D D / M M / Y Y

Insured's occupation

Are you the insured's usual doctor?

No ☐ Yes ☐ For how long? Years Months

What is the current disability and cause?

When did you first treat the insured for this illness or injury? D D / M M / Y Y

Please provide details of treatment

Please provide details of any medication

Are there any medical conditions which have a bearing on this current disablement?

No ☐ Yes ☐ Please provide details

Has the insured ever received a medical diagnosis, treatment, operation or attention for this or similar disablement or related cause?

No ☐ Yes ☐ Please supply the following details (provide on a separate page if insufficient space)

Date	Nature of disability	Date	Nature of disability
D D / M M / Y Y		D D / M M / Y Y	
D D / M M / Y Y		D D / M M / Y Y	
D D / M M / Y Y		D D / M M / Y Y	

If not by yourself, name and address of doctor

What is your prognosis?

Please provide details of operations(s) if any, and date(s)

Have you any reason to:

Suspect that the Insured's disablement has resulted from or been contributed to by the influence of intoxicating liquor or drugs?

No ☐ Yes ☐

Suspect that the Insured's disablement has resulted from or been contributed to by an intentionally self-inflicted injury?

No ☐ Yes ☐

Has the Insured been hospitalised? No ☐ Yes ☐ Number of days

Has the Insured been **totally disabled** from performing:

Each and every duty pertaining to his or her usual occupation?

No ☐ Yes ☐ State period: from D D / M M / Y Y to D D / M M / Y Y

Any other gainful occupation?

No ☐ Yes ☐ State period: from D D / M M / Y Y to D D / M M / Y Y

is the insured capable of performing light or limited duties?

No ☐ Yes ☐ State period: from D D / M M / Y Y to D D / M M / Y Y

Nature of light or limited duties

Hours/day and days/week

If total disablement has ceased, on what date did you release the Insured to perform any remunerative duties?

D D / M M / Y Y

If total disablement still exists, on what date is it likely to cease?

D D / M M / Y Y

Please make sure all answers have been answered and printed correctly and include copy hospital letters relating to the claimed condition.

Signature of Medical Practitioner

Print name

Date

D D / M M / Y Y

Qualifications

Address of practice

Postcode

Telephone number

Facsimile number

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