CGU SEE IT THROUGH.

PERSONAL ACCIDENT OR ILLNESS
CLAIM REPORT

Please answer all questions. This will help us process your claim quickly.
If you need more space to answer any of the questions, please use a separate sheet of paper.
Any attachments will form part of this claim report and the declaration will include them.

1. Policy number (from your schedule) Expiry date D D / M M / Y Y

You can find the information for question 1 on your policy or renewal schedule.

2. Policyholder (surname, company, partnership) Given name(s)

3. Address Postcode

4. Private telephone no. Business telephone no. Facsimile no.

Email address

5. Are you registered for GST purposes?

No ☐ Yes ☐ What is your ABN?

What was your 'Entitlement to an Input Tax Credit' (EITC%) on your premium payment for this policy? %

Questions 6 – 27 to be answered by the insured person, or the policyholder if the insured person is not able to write the answers.

Insured person's details

6. This claim is for: ☐ Weekly benefits for the period shown in the accompanying Certificate of Incapacity, and/or

☐ Lump sum benefits under event(s)

7. Surname of person incapacitated (insured person) Given name(s)

8. Address Postcode

9. Private telephone no. Business telephone no. Email

Should we continue to contact you about this claim, instead of the policyholder? Yes ☐ No ☐

10. Date of Birth D D / M M / Y Y Occupation Usual duties

11. Relationship to policyholder

Injury details (Answer questions 12 – 17 only if you have had an accident)

12. What is the nature of the injury or injuries?

13. When did the accident happen?

D D / M M / Y Y Time a.m. ☐ p.m. ☐

14. Where did the accident happen? At work ☐ Travelling to or from work ☐ Other ☐

15. How did the accident happen? (Describe exactly what you were doing at the time of the accident)

16. Did you drink any alcohol, or take any drugs or medication in the 12 hours prior to the accident?

No ☐ Yes ☐ ▶ What did you drink or what drugs or medication did you take?

▶ When? How much?

17. Were there any witnesses to the accident?

No ☐ Yes ☐ ▶ Name

Address

Postcode

Illness or disease details (Complete questions 18 – 20 only if you are suffering from an illness or a disease)

18. What is the illness or disease?

19. When did the symptoms first appear? D D / M M / Y Y

20. Have you suffered from these or similar symptoms before?

No ☐ Yes ☐ ▶ State when

▶ Provide details

Further details

21. When did you first consult a medical practitioner for this injury, illness or disease? D D / M M / Y Y

22. Name of medical practitioner

Address

Postcode

23. Who is your usual medical practitioner?

Address

Postcode

24. Can you make a claim under any other insurance policy, or medical or hospital fund for this injury, illness or disease?

No ☐ Yes ☐ Name of insurance company or fund | Policy/reference no. | Type of cover

25. Have you been able to carry out any of the usual duties of your usual occupation?

No ☐ Yes ☐ When did you return to your usual duties?

D D / M M / Y Y

What duties, if any, have you been able to do?

What duties, if any, have you **not** been able to do?

26. Have you been advised to have an operation, undergo treatment or take medication for this injury, illness or disease?

No ☐ Yes ☐ State the nature of the operation, treatment or medication recommended

27. Have you sought medical advice for **any** injury, illness or disease in the past five years?

No ☐ Yes ☐ State the nature of the injury, illness or disease

State the name and address of the medical practitioner you consulted

Name

Address

Postcode

Declaration

(This section must be signed by the insured and also the policyholder where the policyholder differs to the insured person)

I declare that to the best of my knowledge and belief the information in this form is true and correct and I have not withheld any relevant information.

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.

Signature of the insured person

Date

D D / M M / Y Y

Signature of the policyholder or person with authority to sign for and on behalf of the company or partnership

Date

D D / M M / Y Y

Please indicate the number of additional pages attached to this claim report

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CERTIFICATE OF INCAPACITY

Important Notes

This certificate must be completed by the treating medical practitioner.

To assist in answering Question 12:

'Total Incapacity' is expressed in the policy as:

'The insured person becoming totally incapable of carrying out all of the usual duties of his or her usual occupation. There must be no usual duties at all that the insured person can carry out'.

'Partial Incapacity' means that the insured person is totally incapable of carrying out some of the usual duties of his or her usual occupation.

Any such incapacity must result solely and directly from: (a) an injury suffered in an identifiable accident, or (b) an illness or disease.

Any cost for preparation of this certificate must be paid by the insured.

1. State the name of the patient you are treating for the injury, illness or disease described in question 12 or 18 of the Claim Report.

Postcode

2. What are the patient's present symptoms?

3. What is your diagnosis?

4. When did the patient first consult you about the injury, illness or disease described in question 12 or 18 of the Claim Report?

D D / M M / Y Y Time a.m. p.m.

5. Have you ever treated the patient previously for the injury, illness or disease described in question 12 or 18 of the Claim Report?

No Yes State the dates of previous treatments

6. If you are treating an injury, is it consistent with the cause as described in questions 12 or 18 of the claim report?

Yes No State your opinion of the cause

7. What treatment is the patient currently receiving for this injury, illness or disease?

8. Is the patient's current injury, illness or disease a recurrence or an aggravation of a pre-existing medical condition?

No Yes When did the patient first consult you for the original condition?

D D / M M / Y Y

9. Does the patient suffer from any other injury, illness or disease that may have contributed to, or that may delay recovery from, the present injury, illness or disease?

No Yes What is the other injury, illness or disease?

10. Does the patient have any addiction to alcohol, drugs or medication?

No ☐ Yes ☐ ▶ What type of addiction?

▶ What is the effect of the addiction on the patient's current incapacity?

11. Has the patient fully recovered from the present injury, illness or disease?

No ☐ Yes ☐ ▶ State the date of recovery

D D / M M / Y Y

12. If, in your opinion, the patient has been incapacitated **solely and directly** as a result of the present injury, illness or disease, state the periods of incapacity and indicate whether the incapacity is total or partial:

a. Total incapacity – being totally incapable of carrying out all of the usual duties of the patient's usual occupation

From D D / M M / Y Y To D D / M M / Y Y

i. When do you expect the patient to be able to carry out some of the usual duties of the patient's usual occupation?

Date of partial recovery D D / M M / Y Y

ii. When do you expect the patient to be fully recovered?

Date of full recovery D D / M M / Y Y

b. Partial incapacity – being totally incapable of carrying out some of the usual duties of the patient's usual occupation:

From D D / M M / Y Y To D D / M M / Y Y

i. When do you expect the patient to be fully recovered?

Date of full recovery D D / M M / Y Y

13. Are you the patient's usual medical practitioner?

Yes ☐ ▶ State how long you have treated the patient ☐☐ years

▶ State all of the complaints the patient has suffered from during the past five years

No ☐ ▶ State why you were consulted

▶ State the name of the referring medical practitioner

Medical practitioner's declaration

I certify that to the best of my knowledge and belief the above statements are true and correct.

Medical practitioner's signature

Date

D D / M M / Y Y

Qualifications

Provider no.

Business telephone no.

Address

Postcode

Medical authority (This section must be completed by the insured person)

We may need further information from your medical practitioner.
Please complete this authority to help us process your claim quickly.

This is my authority for you to provide CGU Insurance Limited with details of my medical history relating to the injury, illness or disease referred to in this form. Please release this information when you receive a copy of my claim details and this authority. I accept that I must pay any fee charged for this information.

Signature of the insured person

Date

D D / M M / Y Y

As part of this claim report please arrange for your treating medical practitioner to complete the Certificate of Incapacity.

When complete, please forward the report to:
Liabilityclaims@cgu.com.au or
CGU Insurance, GPO Box 4756 MELBOURNE VIC 3001 or
our agent or your broker or
your local CGU Insurance office

CGU Claims Tel 13 24 80 (13 CGU 0)

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