Personal Accident and/or Sickness

Important: Please read before you complete this form

1. Please provide responses to all of the information required within Sections 1–5 to avoid any delays to your claim.
2. Please ensure Section 6 – Declaration is signed and dated.
3. Your Employer is to complete Section 7: Employer's Statement of the claim form.
4. Your treating Doctor is to complete Section 8: Doctor's Statement.
5. Please attach a copy of your most recent payslip prior to your disablement.
6. Please attach a copy of an updated resume / employment history
7. Please scan and email the claim documentation to Arch Insurance at AHclaims@archinsurance.com.au
8. The issue of this form is not an admission of liability.

Please note you may be required to provide additional supporting information to assist with the assessment of your claim. For your specific claim, this information is including, but not limited to:

Medical and Additional Expenses

- Medical Certificate and Reports
- Original Medical Receipts
- Information from your private health insurer

Arch Underwriting at Lloyd's (Australia) Pty Ltd

Sydney: Level 10, 155 Clarence Street, Sydney NSW 2000 | P: +61 2 8284 8400 F: +61 2 8088 1024

Melbourne: Suite 11.02, Level 11, 360 Collins Street, Melbourne VIC 3000 | P: +61 3 9629 5444 F: +61 3 9629 1854

E: AHclaims@archinsurance.com.au

archinsurance.com.au

Pursuing Better Together®

Section 1: Policy and Personal information

Policy Number | Policy Holder Name:

Title | Gender

Given Name(s)

Family Name | Date of Birth

Residential Address

Suburb | State | Postcode

Email Address

Daytime Contact Number | Alternative Number

Employer's Name:

Occupation, Trade or Profession | Work Site / Location

Please confirm your usual duties, state the nature of your employment
(full-time, part-time or casual) and average hours worked per week.

What are your gross weekly earnings? | What are you claiming?

☐ Weekly Benefits ☐ Capital Benefits (lump sum) ☐ Non-Medicare Medical Expenses (*If applicable*)

Section 2: Electronic Funds Transfer (EFT) authorisation and GST information

Please provide bank and account details for payment:

BSB Number (6-Digits)	Account Number	Account Holders Name	Bank	Bank Swift Code (International Payments)	Bank Account Currency (International Payments)	Bank Address (International Payments)

If you are a sole trader or own your own business, please complete the following table:

a) Are you registered for GST Purposes? Y N

b) What is your Australian Business Number (ABN)?

c) 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? Y N

d) 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%) %

Section 3: Details of Injury/Incident

To be completed if Claimed Condition is a result of an Injury/incident

Date of injury/incident:

Address where incident occurred:

Were there any witnesses to the injury/incident? Y N

If yes, please provide name and address of witness:

Please describe how the injury/incident occurred:

Please state the diagnosis(es) of your claimed condition:

Please state the symptoms of your claimed condition:

Have you previously been treated from a similar or same injury? Y N

If yes, please give details

Please give the details of previous claims made for any previous injury against any insurance company. Please include Claim number, name + address and number of insurer. (Please attach a separate sheet if insufficient)

During the 24 hours prior to the injury/incident, did you consume any alcohol or drugs? Y N

If yes, please state types and quantities:

Section 4: Details of Sickness/Illness

To be completed if claimed condition is a result of an Illness/Sickness

Please state the diagnosis(es) of your claimed condition(s)

When did symptoms first arise?

Have you suffered from this condition before? Y N

If yes, when and how long were you disabled?

Section 5: Treatment and Return to work

Please outline all treatment received to date as well as any future treatment that is recommended by your treating Doctor. Please include any relevant medical documents, reports or investigative scans.

When did you first cease work due to your claimed condition?

If you have returned to work since your initial cessation, please state the date(s)/period(s) of time in which this occurred and in what capacity (part- or full-time)

From (DD/MM/YYYY) To (DD/MM/YYYY)

When did you first consult a Doctor for your claimed condition? (DD/MM/YYYY)

Confirm the date in which a diagnosis was made for your claimed condition?

Name of current Usual Doctor + Clinic

Telephone number

Email Address

Clinic Name/ Address:

Name of Specialist and specialty + Clinic

Telephone number

Email Address

Clinic Name/ Address:

How long have you known each Doctor?

Doctor:	Years	Months
Doctor:	Years	Months

If you have visited other Doctors from those listed above, please provide the Doctor's information below for the past 5 years (If this is not completed, it may delay your claim):

Please give the details of all treating Doctors and allied health professionals in the table below:

Practitioner's name	Address	Telephone

Was hospital treatment required? Y N

If Yes, please complete the following regarding your Hospital Stay (*please attach separate sheet if insufficient space*)

From	To	Hospital Name	Hospital Address

Please advise of any secondary condition(s) (past or present) that may be affecting your ability to return to work:

Please advise if you are currently:

Recovered Y N

When did you return to work?

Partially Disabled (able to perform some work duties) Y N

When did you return to work on a partial capacity/reduced duties/hours?

Totally disabled (unable to perform any work duties) Y N

When do you expect to return to work?

Will you make or are you entitled to make a claim for benefits under any other insurers, including but not limited to, Workers' Compensation Act, Transportation Act, Government benefits, Health funds etc due to your claimed condition? Y N

If yes, please provide the details in the below table:

Claim Number (if known)	Name	Address

Please advise of any secondary condition(s) (past or present) that may be affecting your ability to return to work Y N
If yes, please give details

Section 6: Privacy statement, medical authority and declaration

Arch Insurance
Privacy Statement

I/We agree that, by signing this form, the personal information I/we provide to Arch may be collected, held, used and disclosed in the manner set out in the Arch Privacy Statement found at www.archinsurance.com.au, including for the processing of this claim.

Medical Authority

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

I agree to Arch using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to Arch's Privacy Policy and this document.

I/We hereby authorise any hospital, medical practitioner, and any other person or entity who has attended to or examined me, to provide Arch with copies of medical records (including but not limited to consultations, prescriptions, treatment, hospital records, reports, medical correspondence) as requested.

Declaration

I/We certify that the information given in this form is truthful, accurate and complete. No information likely to affect this claim has been withheld. I/We understand that this claim may be refused if information is untrue, inaccurate or concealed.

I will use my best endeavours and render all reasonable assistance and cooperation to Arch in the assessment of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, Arch may not be able to process or assess my claim.

Name of Claimant:	Signature of Claimant:
Date: (DD/MM/YYYY)	
Name of Witness:	Signature of Witness (any adult person):
Date: (DD/MM/YYYY)	

Section 7: Employer statement

To be completed by your employer

We are unable to process benefit payments without confirmation of income

Employers Name:

This is to state that: has been unable to attend their occupation as a result of Injury or Sickness

From: Until:

Their 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: Y N

If no, please provide the last date they were employed:

Sick leave entitlement as at the date of injury or illness. Days

Has been employed since: (DD/MM/YYYY)

Has a claim for Worker's Compensation been lodged ☐ Y N

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission/CTP? ☐ Y N

Signature of supervisor or manager:

Name of supervisor or manager (please print):

Telephone number:

Email address:

Date: (DD/MM/YYYY)

Section 8: Doctor's statement

To be completed by your treating doctor

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

Patients Name:

DOB:

Please state the patient's diagnosis(es) and symptoms

Cause:

Is this condition ☐ an injury ☐ an illness

Does the patient have any other injuries or illnesses that are contributing to the claimed condition? Y N

If yes, please provide details:

Is the claimed condition due to injury or illness arising out of the patient's employment? Y N

If yes, please provide details:

Is the claimed condition a result of a sporting incident? Y N

If yes, please provide details:

Date of onset/first symptoms?

When did the patient first consult you/your clinic for this claimed condition?

Has the patient ever had the same or similar condition? Y N

If yes, please advise when and the diagnosis:

Name of patient's usual doctor/medical practice:

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

If the patient has been hospitalised, please provide the name of the hospital and dates/periods they have been admitted

Please outline all treatment received to date as well as the ongoing recommended treatment/recovery plan for your patient. Please include any medical documents, reports, investigative scans, surgeries etc

Has the patient been referred to a specialist? Y N

If yes, please provide the name, specialty, address, phone number and date of referral of the specialist:

Is your patient still currently disabled? Y N

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)
Please advise applicable unfit dates

OR:

Partially disabled (able to perform part of their occupation)

Please advise applicable partial work capacity dates

Please include of any restrictions related to the disablement ie lifting restrictions, hours capable of working, breaks required etc

Please comment on your patient's overall prognosis:

Please comment on their expected recovery in the next 3, 6 and 12 months

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? Y N

Name of Company/Contact/Claim Number:

Signature of medical practitioner:

Qualifications (please print):

Telephone number:

Email address:

Address:

Date: (DD/MM/YYYY)

