Journey Group Personal Accident
Claim Form
2024 02

Important: Please read before you complete this form

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2 Please note that Sections 1, 2, 4, 5, 6 & 7 are COMPULSORY.
3. Note: This form can be completed electronically. If completing this form by hand: Please print.
4. The issue of this form is not an admission of liability by Batch Underwriting.

Batch
Accident & Health

01. POLICY AND PERSONAL INFORMATION

ALL QUESTIONS REQUIRE COMPLETION

POLICY NUMBER

EXPIRY DATE

MEMBER NUMBER (IF APPLICABLE)

NAME OF INSURANCE BROKER (IF KNOWN)

NAME OF INSURED COMPANY

TITLE

GIVEN NAME(S)

M F Other

FAMILY NAME

DATE OF BIRTH

RESIDENTIAL ADDRESS (CANNOT BE A PO BOX)

SUBURB

STATE

POSTCODE

EMAIL ADDRESS

DAYTIME CONTACT NUMBER

ALTERNATIVE NUMBER

OCCUPATION, TRADE OR PROFESSION

USUAL DUTIES

02. PAYMENT DETAILS

COMPULSORY

Please provide bank and account details for payment

ACCOUNT HOLDERS NAME

BSB NUMBER (6 DIGITS)

ACCOUNT NUMBER

BANK

(Alternatively supply a deposit slip noting the following information)

03. DETAILS OF ACCIDENT

COMPLETE IF AS A RESULT OF AN ACCIDENT

DATE OF ACCIDENT | TIME | AM/PM | ACCIDENT CITY | ACCIDENT COUNTRY

ADDRESS WHERE ACCIDENT OCCURED (IF APPLICABLE)

Were there any witnesses to the accident? Yes ☐ No ☐

WITNESS NAME

WITNESS ADDRESS

Please describe how the accident / injury occurred

What were the injuries?

Have you previously been treated for any serious injury? Yes ☐ No ☐

If Yes, please give details

Give details of any previous claim made for any previous injury against any insurance company (please attach separate sheet if insufficient space)

04. TREATMENT

COMPULSORY

Was hospital treatment required? Yes No Yes ☐ No ☐

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

From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

When did you stop work? TIME AM/PM

When did you first obtain treatment from doctor? TIME AM/PM

NAME OF DOCTOR ADDRESS

Is this doctor still treating you for the injury / illness? Yes ☐ No ☐

Is this doctor your regular doctor? (If No, please give details) Yes ☐ No ☐

NAME OF DOCTOR ADDRESS

Is there any condition (past or present) affecting your current disability? Yes ☐ No ☐

If Yes, please give details

Are you now:

Recovered Yes ☐ No ☐ When did you return to work?

Partially Disabled Yes ☐ No ☐ When did you return to work undertaking partial duties?

Totally Disabled Yes ☐ No ☐ When do you expect to return to work?

Have you made, or will you make, a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury? Yes ☐ No ☐

	Claim Number (if known)	Name	Address
Employer			
Workers Comp/Transport Insurer			

Are you entitled to claim benefits for this Injury / Illness from other Insurers, Persons, Company, Health Fund, Friendly Society or Government? Yes ☐ No ☐

Name	Address

05. TO BE COMPLETED ONLY IF CLAIMING LOSS OF INCOME

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

1. If self employed please indicate by ticking the box ☐ Confirmation of earnings MUST be submitted with claim form (i.e. Income Tax Return & Profit/Loss Statement)

2. If employed as a wage earner the following is to be completed by your employer (or attach Pay History Report from the employer for the 12 month period immediately preceding the injury or sickness).

I hereby certify that _____ has been unable to attend his/her usual occupation with the company as a result of an

Injury / Illness suffered whilst _____ on the __ __ __ __ __ __ __ __

He/She has been incapacitated since __ __ __ __ __ __ __ __ and is expected to/did resume duties on __ __ __ __ __ __ __ __

His/Her Gross Salary, exclusive of bonuses, commission, allowances etc. at the Date of Injury was $ _____ Per week

During the period of incapacity he/she received $ _____ from __ __ __ __ __ __ __ __ to __ __ __ __ __ __ __ __

Please specify type of pay _____

(If there is insufficient room to specify pay types, please provide pay history copies or print-outs)

NAME OF COMPANY

HAS BEEN EMPLOYED SINCE __ __ __ __ __ __ __ __

ADDRESS

SIGNATURE OF SUPERVISOR OR PAYMASTER

DATE __ __ __ __ __ __ __ __

NAME (PLEASE PRINT)

TELEPHONE NUMBER

06. DECLARATION

COMPULSORY

I/We declare that to the best of my knowledge and belief, the information provided on this claim form and in any attached documentation is true and correct and that I/We have not withheld any relevant information.

I/We consent to Proclaim and/or its agent using the personal information I/We have provided for the purpose of processing my claim.

I/We understand that if I/We choose not to provide the required details, this is my/our choice; however, Proclaim and/or its agent may not be able to process my/our claim.

I/We consent to Proclaim and/or its agent disclosing my/our personal information to other insurers, an insurance reference service, claims adjusters, lawyers and other consultants or as required by law.

I/We also consent to Proclaim and/or its agent disclosing my/our personal information to and/or collecting additional information about me/us, from investigators or legal advisors.

I/We also consent and authorise any hospital and/or physician who has treated me to provide Proclaim and/or its agent with copies of medical records or of my past medical history, as requested.

I/We acknowledge that I/We have read and understood the Privacy Statement found at www.batchunderwriting.com and consent to the collection, storage, use and disclosure of personal and sensitive information to all persons affected by this claim.

I/We acknowledge that if I/We do not agree to the collection of this personal information then Proclaim and/or its agent will be unable to process my/our claim.

SIGNATURE OF CLAIMANT

DATE __ __ __ __ __ __ __ __

SIGNATURE OF THE INSURED (if other than claimant)

DATE __ __ __ __ __ __ __ __

07. MEDICAL CERTIFICATE

This section must be fully completed by attending doctor - any fee for completion of this section is the responsibility of the insured person

COMPULSORY

TITLE: GIVEN NAME(S): FAMILY NAME:

DATE OF BIRTH: M F Other HEIGHT: WEIGHT:

Date of Injury:

When did you first examine the patient?

Please give full details of circumstances of injury

What was your clinical diagnosis?

If not with you, when did the patient first receive medical attention for this condition?

With whom/where?

Has the patient ever suffered with this or any similar condition before the present episode? Yes No

If YES, please give details including dates treatment and consultation:

Are you the patient's usual doctor? Yes No

If NO, please give name and address of claimant's usual doctor:

Disability

On what date did incapacity commence?

Is patient still incapacitated? Yes No

If YES please estimate when you estimate the patient to be able to return to work?

OR Please complete:

I estimate the patient should have functional capacity to return to work in DAYS MONTHS YEARS

I intend to review the patient on:

If the patient is no longer disabled, when did he/she return to work?

Please detail any investigations and provide results:

Any other comments/clinical findings?

Was the patient hospitalised as a result of this condition? Yes ☐ No ☐

If YES, which Hospital?

How many days was the patient hospitalised? ☐☐ DAYS FROM ☐☐ ☐☐ ☐☐☐☐ TO ☐☐ ☐☐ ☐☐☐☐

Detail any Surgical Procedures performed or planned:

Procedure: Date performed/to be performed: ☐☐ ☐☐ ☐☐☐☐

Procedure: Date performed/to be performed: ☐☐ ☐☐ ☐☐☐☐

Have you referred the patient to any other Medical Practitioner? Yes ☐ No ☐

If YES, give Name & Speciality

Detail any Treatment recommended? i.e. physiotherapy

Is there any other injury, or condition impacting the patient's recovery from the claimed condition?

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

If YES, have you discussed Workers' Compensation with the patient?

Do you believe the patient will recover or is any Permanent Impairment likely?

SIGNATURE DATE ☐☐ ☐☐ ☐☐☐☐

Please use validation stamp or complete in block capital:

PRINT NAME: QUALIFICATIONS:

PRACTICE/CLINIC: ADDRESS:

PHONE: FAX: EMAIL:

OR VALIDATION STAMP