CLAIM FORM

point INSURANCE

CLAIM FORM INSTRUCTIONS

To avoid any delays with the processing of your claim, please ensure that all necessary sections are fully completed and that all required documentation is provided.

There are 3 sections to this claim form and all sections must be completed, as follows:

Section 1:

CLAIMANT CERTIFICATION is to be completed by the person making the claim.
If you are making a claim for an **Injury**, please complete the **Injury Section** on Page 3 as well as Pages 2 and 5.

If you are making a claim for a **Sickness**, please complete the **Sickness Section** on Page 4 as well as Pages 2 and 5.

Please be sure to sign and date the Declaration & Information Authorities on Page 6.

Section 2:

MEDICAL CERTIFICATION is to be completed by your treating General Practitioner or Specialist. Please be aware that any fee incurred for completing this form is the responsibility of the person making the claim.

Section 3:

FINANCIAL CERTIFICATION is to be completed by you if you are self-employed or by your employer.

If you are **self-employed**, complete Page 9 and follow the instructions at the top of the page about the importance of supplying appropriate financial documentation.

If you are an **employed** individual, please have your employer complete Page 10 and follow the instructions at the top of the page about supplying appropriate financial documentation.

HELPFUL NOTE: AGREED VALUE POLICY
If you have an Agreed Value Policy, you are not required to provide any financial documentation with your claim form. If you are unsure as to whether you have an Agreed Value Policy, please refer to your Policy Schedule or contact your Broker for clarification.

The completion of this form is used to initiate a claim. If your claim is accepted, the insurer may require you and/ or your treating medical practitioners to complete Progress Claim Forms whilst you are unable to return to work.

It is important to note that the issuance of this form is not an admission of liability by Point Underwriting Agency Pty Ltd.

Please send the completed form and associated documentation to:

Point Underwriting Agency

Address: PO Box 744, Manly NSW 1655
Email: enquiries@pointinsurance.com.au
Phone: (02) 9970 7378 or Toll Free on 1300 362 766
Fax: (02) 9913 8078

SECTION 1 – CLAIMANT CERTIFICATION

Policy No

1.1 YOUR DETAILS

Title | First Name | Surname

Date of Birth / / Female Male

Residential Address

Suburb/Town | State | Postcode

Mobile Number | Alternate Number ( ) | Email Address

1.2 DETAILS OF YOUR OCCUPATION

What is your occupation?

How many years have you been in this occupation? years

How many hours do you work per week? hours

When did you join your current employer or start operating your business? / /

List here all the duties of your occupation and the average time (percentage) you perform each duty per week

Percentage of time doing and type of sedentary light duties	Percentage of time doing and type of manual duties

Employee | Name of Employer

If you are an employee, please have your employer complete Section 3, Page 10

Self Employed

If you are self employed, please complete Section 3, Page 9

1.3 ELECTRONIC FUNDS TRANSFER (EFT) DETAILS FOR CLAIM PAYMENTS

IMPORTANT: Should your claim be accepted & benefits are payable we will require your account details. Please be sure to complete the following section so that payments can be processed without delay.

Account Name: | BSB Number (6-digit number):

Name of Bank/Credit Union: | Account Number:

I authorise Point Underwriting Agency Pty Ltd to directly credit claim benefits to my account as noted above.

Signature of Claimant authorising EFT benefits:

Date: / /

SECTION 1 - 1.4 CLAIM FOR INJURY SECTION

If you are claiming for a sickness then you need to complete Section 1.5 on page 4.

1. What is the injury causing your disability?

2. Please describe how the injury occurred:

3. What is the street address where you were injured? Suburb/Town State

4. Were you working, or at work, at the time of the injury? No ☐ Yes ☐

5. Were you travelling to, or from, work at the time of the injury? No ☐ Yes ☐

6. Date of injury ☐☐ / ☐☐ / ☐☐☐☐ Time of injury ☐☐ : ☐☐ am ☐ pm ☐

7. Did you cease all duties as a result of this injury?

   Yes ☐ If yes, provide the date you ceased work ☐☐ / ☐☐ / ☐☐☐☐

   No ☐ If no, when do you expect to do so? ☐☐ / ☐☐ / ☐☐☐☐

8. Were there any witnesses to the accident? No ☐ Yes ☐ If yes, complete the following details:

   Witness Name Mobile Number

   Address Suburb/Town State

9. During the 24 hours before the injury, did you consume any alcohol or drugs (not prescribed to you by a qualified medical practitioner)?

   No ☐ Yes ☐ If yes, please provide details as to the type and quantity consumed:

10. Have you ever injured this part of your body before?

    No ☐ Yes ☐ If yes, please provide details below:

    Nature of injury on (the date) ☐☐ / ☐☐ / ☐☐☐☐

    Name of treating Doctor Address

11. Are you entitled to, and/or have you made, or intend to make, a claim for benefits of any type in regard to your injury? (eg, worker's compensation, public liability, compulsory third party (CTP), travel insurance, Centrelink, sports insurance, etc)

    No ☐ Yes ☐ If yes, please provide details below:

    Claim made on (date) ☐☐ / ☐☐ / ☐☐☐☐ Claim made against (organisation) Claim Number

    Claim outcome (eg, accepted, declined etc) Type of Cover (ie Workers compensation)

12. Are you in receipt of any wages, salary, paid sick leave or income from any other source?

    No ☐ Yes ☐ If so, please provide details:

13. Have you returned to work in any capacity?

    No ☐ Yes ☐ Full Time capacity ☐ Date ☐☐ / ☐☐ / ☐☐☐☐

    Part Time capacity ☐ Date ☐☐ / ☐☐ / ☐☐☐☐

14. If you have not yet returned to work, when do you expect that you will be able to do so? ☐☐ / ☐☐ / ☐☐☐☐

Continue on Page 5

SECTION 1 - 1.5 CLAIM FOR SICKNESS

If you are claiming for an injury then you need to complete Section 1.4 on page 3

1. What is the sickness/illness causing disability?

2. When did you first experience symptoms?

   / /

3. What were the symptoms of the sickness that you first experienced?

4. Was your sickness caused, or contributed to, by work?

   No ☐ Yes ☐ If so, how?

5. Did the sickness cause you to completely cease work?

   Yes ☐ If yes, provide the date you ceased work / /

   No ☐ If no, when do you expect to do so? / /

6. Have you ever had this sickness, symptoms of this sickness, or a similar sickness before the period for which you are currently claiming?

   No ☐ Yes ☐ If yes, please provide the following details:

   Nature of Condition

   Doctor Consulted

   Date of Occurrence / /

7. Are you entitled to, and/or have you made, or intend to make, a claim for benefits of any type in regard to your sickness? (eg, worker's compensation, income protection, travel insurance, Centrelink, etc)

   No ☐ Yes ☐ If yes, please provide details below:

   Claim made on (date) / /

   Claim made against (organisation)

   Claim Number

   Claim outcome (eg, accepted, declined etc)

   Type of Cover (ie Workers compensation)

8. Are you in receipt of any wages, salary, paid sick leave or income from any other source?

   No ☐ Yes ☐ If so, please provide details:

9. Have you returned to work in any capacity?

   No ☐ Yes ☐ Full Time capacity ☐ Date / /

   Part Time capacity ☐ Date / /

10. If you have not yet returned to work, when do you expect that you will be able to do so? / /

11. If you have not yet returned to work, how is the sickness currently preventing you from working?

Continue on Page 5

SECTION 1 - 1.6 YOUR MEDICAL TREATMENT

1. Who is your usual treating doctor?

Doctor's Name

Telephone Number ( )

Full address of practice

Suburb/Town

State

How long have you been seeing this doctor? Days Months Years

2. When did you first see a doctor for the injury or sickness? Date / /

Was the doctor you first saw your usual treating doctor?

Yes No If no, please provide the following details:

Doctor's Name

Telephone Number ( )

Full address of practice

Suburb/Town

State

How long have you been seeing this doctor? Days Months Years

3. Were you admitted to Hospital?

No Yes If admitted, which hospital were you admitted to? (please attach a copy of the hospital admission and/or discharge summary)

Hospital

Date of Admission / / Time of Admission : am pm

Date of Discharge / /

4. Have you been referred to a specialist?

No Yes Please provide the names and addresses of specialists you have been referred to.

Specialist Name

Speciality

Address

Suburb/Town

State

Telephone Number ( )

5. Have you seen this specialist before?

No Yes If yes, please provide date of previous consultation: Date / /

Reasons for previous consultation:

6. What tests have you undergone (for example CT scan, MRI, blood tests) and when? Please attach copies of any reports.

Date	Test

7. What medical treatment (including medication and therapies) are you currently receiving and how frequently?

Continue on Page 6

SECTION 1 - 1.7 DECLARATION AND INFORMATION AUTHORITIES

I understand that Point Underwriting Agency Pty Ltd (ABN 53 605 479 070, AFS License No. 477471) may need to access, collect and disclose information about me in order to be able to assess my claim for benefits.

In order to do so, I (insert your full name here)

hereby agree that I have read, understood and agree to the collection, use and disclosure of my personal information by Point Underwriting Agency Pty Ltd as outlined in the Privacy Notice below.

In addition and without limiting the above, I authorise Point Underwriting Agency Pty Ltd to collect and disclose any information about me from and to any organisation or person including the following (which includes their current and former capacities and any organisation or person that may replace them): Medicare, any insurance or health insurance company, other insurance intermediaries, Centrelink, any hospital, physician, medical practice, medical services provider, medical therapy provider, employer, investigators, assessors and loss adjustors, other parties we may be able to claim or recover against, insurance reference bureau, financial institutions including banks, the Australian Taxation Office and my accountant.

In providing or obtaining information about me, I understand that Point Underwriting Agency Pty Ltd will use that information in the assessment of my claim, and that if I do not provide or permit access to this information my claim may not be able to be assessed.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving Point Underwriting Agency Pty Ltd notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I have made any misrepresentations, false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that subject to law, the policy may be cancelled and / or Point Underwriting Agency Pty Ltd may refuse to pay a claim.

Signature

Date

☐☐ / ☐☐ / ☐☐☐☐

To be completed if another person has signed on behalf of the person making the claim:

Name of person who signed on behalf of the claimant

Relationship to the claimant

Reason why the claimant could not sign

SECTION 1 - 1.8 PRIVACY NOTICE

Point Underwriting Agency Pty Ltd (Point) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principals.

A copy of our Privacy Policy is available on our website at www.pointinsurance.com.au or by contacting our customer relations team on 1300 362 766.

Your personal information will be used by Point, or any third party that Point provides the information to, for the purposes 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 or your Health Insurance Claims history, including Medicare;
- Any information relating to any relevant insurance policy, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed;
- Any other information in relation 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, Point may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (e.g. Centrelink or the Australian Tax Office), your doctor or other health service provider, your employers (past and present) and / or your accountant.

Point 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 insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. Point may also disclose your personal information to witnesses in relation to 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 office on 1300 362 766 or email enquiries@pointinsurance.com.au.

SECTION 2 – MEDICAL CERTIFICATION

This part of the claim form must be completed by a registered doctor

Please note that any fee incurred for the completion of this medical certification form is the responsibility of the patient.

SECTION 2 - 2.1 PATIENT DETAILS

First Name

Surname

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Height ☐☐☐ cm

Weight ☐☐☐ kg

1. How long has the patient been known at your practice? ☐☐ days ☐☐ months ☐☐ years
2. Are you the patient's usual treating doctor?

   Yes ☐ No ☐ If not, please provide details of the physician who is:

3. Patient's occupation

   What percentage of the patient's duties are:

   Manual ☐☐☐ % Sedentary ☐☐☐ %
4. Medical diagnosis causing disablement from work
5. When did the patient first consult you in relation to this medical condition? Date: ☐☐ / ☐☐ / ☐☐☐☐
6. Is the medical condition an/a:

   Injury ☐ Date of Injury ☐☐ / ☐☐ / ☐☐☐☐ Cause of Injury Diagnosis Date ☐☐ / ☐☐ / ☐☐☐☐

   Sickness ☐ Date of onset/first symptoms ☐☐ / ☐☐ / ☐☐☐☐ Cause of Sickness Diagnosis Date ☐☐ / ☐☐ / ☐☐☐☐

   Nature of symptoms
7. Was there any previous history of this or of a similar condition?

   No ☐ Yes ☐ If so, please provide full details of the previous history of the injury or sickness:

8. Is the condition due to injury or sickness arising out of the patient's employment?

   No ☐ Yes ☐ If so, please provide details:

9. On what date was the patient first certified unfit for work? ☐☐ / ☐☐ / ☐☐☐☐
10. When considering the patient's occupational duties, do they remain disabled from work?

    No ☐ Date certified fit to return to work ☐☐ / ☐☐ / ☐☐☐☐

    Yes ☐ Please provide appropriate certification dates:

    Totally Disabled from: Date ☐☐ / ☐☐ / ☐☐☐☐ To: Date ☐☐ / ☐☐ / ☐☐☐☐

    Partially Disabled from: Date ☐☐ / ☐☐ / ☐☐☐☐ To: Date ☐☐ / ☐☐ / ☐☐☐☐
11. What duties of their occupation could the patient currently perform and for how many hours per week?

    Duties

    Hours per week ☐☐

SECTION 2 – MEDICAL CERTIFICATION

12. Please list here details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis. Please attach copies of reports.

Date	Test	Result

13. Has the patient been referred to a specialist?

No ☐ Yes ☐ Please provide details below:

Specialist Name

Speciality

Address

Suburb/Town

State

Contact Number ( )

14. What is the current regime of medical treatment? (medication, therapies, surgery etc)

15. Are there any concurrent conditions which are affecting the patient's ability to return to work?

No ☐ Yes ☐ Please state what the concurrent condition is and to what degree it prevents/restricts the patient returning to their occupation

16. Are you providing information in respect of this patient to any other insurer?

No ☐ Yes ☐ If so, which insurer?

DOCTOR'S DECLARATION

We advise that any information received by or requested from you by Point Underwriting Agency Pty Ltd is handled in accordance with the relevant privacy legislation. Should you wish to obtain a copy of our Privacy Policy, it is available upon request or you can visit our website at www.pointinsurance.com.au.

The information provided in this medical certificate is a truthful, comprehensive and accurate account of the patient's medical condition, medical history and level of disability.

Signature

Date ☐☐ / ☐☐ / ☐☐☐☐

Name

Qualifications

Practice Address

Suburb/Town

State

Postcode

Telephone Number ( )

Fax Number ( )

Email

SECTION 3 – FINANCIAL CERTIFICATION

IMPORTANT INSTRUCTIONS

If you are **SELF-EMPLOYED** you must complete this page. You must provide a copy of your entire Individual Taxation Return & Notice of Assessment (NOA) for the financial year immediately prior to your ceasing work due to your Injury or Sickness and if you are a Company/Partnership please also provide a copy of your entire Business Taxation Return. If you operate a Trust as part of your business structure you must also include a full copy of the entire Trust Taxation Return.

SECTION 3 - 3.1 SELF EMPLOYED

Business Structure (i.e. sole trader, partnership, trust)

Business/Company Name

ABN

Business Address

Suburb/Town

State

Postcode

What activity principally generated your income in the 12 months before you ceased work due to injury or sickness?

Have you changed your occupation in the 12 months before you ceased work due to injury or sickness?

No ☐ Yes ☐ If so, please tell us what your occupation has changed from

to

on ☐☐ / ☐☐ / ☐☐☐☐

Was any of the income you earned in the 12 months before you ceased work due to injury or sickness split with a spouse or partner ?

No ☐ Yes ☐ If so, please provide the percentage ☐☐ %

Your Accountant's Name

Accountant Address

Suburb/Town

State

Telephone Number

(☐☐) ☐☐☐☐☐☐☐☐

Email

Did you/your accountant complete and lodge a taxation return for both of the last two financial years?

Yes ☐ No ☐ If no, why not?

SECTION 3 – FINANCIAL CERTIFICATION

IMPORTANT INSTRUCTIONS

If you are an **EMPLOYEE** your employer must complete this page. If you are an **EMPLOYEE**, please provide a copy of your pay slips for the 12 month period immediately prior to you ceasing work.

SECTION 3 - 3.2 EMPLOYEE DETAILS

I hereby certify that (name of Claimant):

has been engaged/employed by the company/business since: / / In the position of:

1. Did the person ENTIRELY CEASE WORK in their employed position?

   No ☐ Yes ☐ If yes, on what date did they completely cease work? Date / /

2. Did the person ONLY PARTIALLY CEASE WORK in their employed position?

   No ☐ Yes ☐ If yes, from when? Date / /

3. Has the Claimant returned to work?

   No ☐ Yes ☐ If yes, please advise from when and at what capacity:

   Date / / Full Time ☐ Part Time ☐

4. During the period of incapacity did your employee receive any of the following:

Paid sick leave ☐ from / / to / / in the amount of $ gross p/w

Workers comp. ☐ from / / to / / in the amount of $ gross p/w

Employee's sick leave entitlement as of the date of injury/illness Days

Gross Weekly Earnings averaged over the 12 months prior to disablement $ per week

Claimant ☐ Employer ☐ If claim benefits are to be paid to the Employer, please complete Section 3 – 3.3 Employer Bank Details below

SECTION 3 - 3.3 EMPLOYER BANK DETAILS

Account Name

BSB Number (6-digit number)

Name of Bank/Credit Union

Account Number

SECTION 3 - 3.4 EMPLOYER DETAILS

Name of person completing this form

Position (e.g. manager, owner, HR)

Company /Business Name

Company / Business Address

Suburb/Town

State

Contact Number

Email

Signature

Date / /