Injury and Sickness Benefit Claim Form

This claim form consists of 3 parts and all sections must be completed in full.

Section A Your Statement This section is to be completed by the **Person Claiming** or such authorised person.

Section B Doctor Statement Your **Treating Doctor** must complete this section and we do not hold responsibility for any charges.

Section C Employer Statement This section must be completed by your **Employer**.

Important information

1. A claim cannot be assessed until we receive at a minimum, **all sections of the completed claim form**.
2. Incomplete questions may delay the assessment process and the claim form could be sent back to be completed.
3. To have a valid claim, you must be medically disabled from work for at least the waiting period - Please refer to your policy document.
4. All **medical certificates** must be provided - Please note in order to have a valid medical certificate it must state the medical condition disabling you from work, period disabling you from returning to work and not be backdated.
5. Please ensure you have provided your Treating Doctor with a copy of your job description outlining your occupational duties.
6. Please ensure you provide to us **proof of identification** e.g. copy of your driver's licence, proof of age card etc.
7. A full **12 month wage report** prior to your disablement is required with Section C of the claim form along with your **job description** outlining your regular occupational duties.
8. All information provided must be legible.

Please return the completed Claim Form to n2n Claims Solutions

Email: info@n2nclaims.com.au

Post: Locked Bag 3111, Rhodes NSW 2138

If you have any questions, please don't hesitate to contact our claims department on **1800 999 626**

Clear Form

Section A – Your Statement

Your Details

Given name		**Surname**			
Address					
Suburb		**State**		**Postcode**	
Home phone		**Mobile**			
Fax		**Gender**		**Date of Birth**	
Email				**Height (cm)**	**Weight (kg)**
Who are you claiming through?	☐ **Superfund** ☐ **Employer EBA**	**Name**			
If claiming through your Superfund, what is your Membership Number?					
Are you a member of another Superfund (in addition to the above listed, if applicable)?				☐ **Yes** ☐ **No**	
Superfund Name				**Membership No.**	
Do you have other Income Protection / Salary Continuance / Sickness and Accident Cover?				☐ **Yes** ☐ **No**	
If "Yes", provide name of Insurer					
Citizenship	☐ **Australian Citizen** ☐ **New Zealand Citizen**			**If other please specify**	
Are you a smoker?	☐ **Yes** ☐ **No**	**If "No" and you were previously a smoker, when did you cease?**			
Are you a member of a Union?	☐ **Yes** ☐ **No**	**Name**			

Employment Details

Employer name					
Street Address					
Suburb		**State**		**Postcode**	
Work phone		**Work fax**			
Occupation at the time of disablement		**Date commenced employment**			
Employment type	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Project Specific Work				
Current work status	☐ Employed ☐ Resigned ☐ Terminated		**Date Ceased**		
Describe your usual duties					
Do you own any part of the Business or are you Self-Employed?	☐ No ☐ Self-Employed ☐ Owner		**% Owned**		
Do you have any other employment	☐ Yes ☐ No	**Details**			

Medical Details

Is your condition an	☐ Injury **OR** ☐ Sickness		
Description of Injury or Sickness			
If your condition is an Injury, please state exactly how, when and where it occurred. If applicable include any witness names and phone numbers.			
When did symptoms first occur for your medical condition? **Date**		**Time**	
When did you first consult a Doctor for this medical condition? **Date**			
When was your last day at work as a result of this condition? **Date**			
Have you returned to work?	☐ Yes ☐ No		
• **If "Yes", please provide the date you returned** • **If "No", please advise the date you expect to return**			
In your opinion, do you believe your condition is work related?	☐ Yes ☐ No		
In your opinion, do you believe your condition is a result of playing sports?	☐ Yes ☐ No		
Is or was surgery required for your condition?	☐ Yes ☐ No **If "Yes", when was/is surgery?**		
Have you had a similar condition in the past?	☐ Yes ☐ No	**Details**	

If you have had a similar condition in the past, please complete the details below for the physician/specialist you attended.

DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED

Medical Practitioner Details (Please provide a history for over 5 years)

If you've attended **more than 2 medical practitioners over the past 5 years**, please attach a list with the claim form.
Please note if a complete medical history is not provided, your claim may be delayed while we obtain a full Medicare history.

Doctors name		**Practice/Hospital**			
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax number**			
Email Address					
Date first ever attended		**Date last attended**		**Years attended**	
Doctors name		**Practice/Hospital**			
Address					
Suburb		**State**		**Postcode**	
Phone number		**Fax number**			
Email Address					
Date first ever attended		**Date last attended**		**Years attended**	

Your Bank Details (Details are required in order to process any payments, if liability is accepted)

Name of financial institution			
Name on account (e.g. John Smith)			
BSB number		**Account No.**	

Other Benefit Details

Have you or are you planning to lodge motor accident compensation claim?	☐ **Yes** ☐ **No**
Have you or are you planning to lodge a sports insurance claim?	☐ **Yes** ☐ **No**
Have you or are you planning to lodge a Workers Compensation claim?	☐ **Yes** ☐ **No**
Have you or are you planning to lodge a claim with an Employer EBA Policy?	☐ **Yes** ☐ **No**
Have you or are you planning to lodge a claim with any Government benefits?	☐ **Yes** ☐ **No**
Are you making or entitled to lodge a claim with any other insurer or compensation benefit?	☐ **Yes** ☐ **No**

If you have answered "Yes" to any of the above, complete the below and provide details of your claim e.g. acceptance/decline letter, any benefit statements

Insurer/Company name			
Type of claim			
Address			
Contact person		**Contact No.**	
Have you or are you planning to receive any employer benefit? Sick leave etc.	☐ **Yes** ☐ **No**		

Authorised Representative/s (This section is optional)

Complete this section if you **wish to authorise a family member or friend** to assist you with the claims process. It is required to allow us to disclose any personal information about your claim which includes medical, financial, employment and insurance information.

Name of authorised representative			
Representative's relationship to you		**Representative's date of birth**	
Representative's Phone Number		**Email**	

Declaration and Authorisation

Privacy Statement

In this statement "we", "us" and "our" means the Underwriter and n2n Claims Solutions Pty Ltd as its authorised representatives.

We are bound by the obligations of the Privacy Act 1988 (Cth) and the Australian Privacy Principles. This sets out basic standards relating to the collection, use, storage and disclosure of personal information.

Our Privacy Policy, available at www.n2nclaims.com.au or by calling us on 1800 999 626 and it sets out how:

- **we protect your personal information;**
- **you may access your personal information;**
- **you may correct your personal information held by us;**
- **you may complain about a breach of the Australian Privacy Principles and how we will deal with such a complaint.**

We, and our agents, need to collect, use and disclose your personal information in order to assess and manage any claim or obtain feedback on our group services. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to assess or manage a claim.

We may disclose your personal information to third parties who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers (including reinsurers) and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). Some of these parties may be located outside of Australia which includes but is not limited to the United Kingdom.

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- **you have the authority from them to do so and it is as if they provided it to us;**
- **you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the other parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.**

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by us by contacting n2n Claims Solutions on 1800 999 626 or via email at info@n2nclaims.com.au.

By signing this form, you consent to us and the parties mentioned below collecting, using, and disclosing personal and sensitive information about you for the purposes described above of assessing and managing your claim or obtaining feedback on our group services.

1. **Parties may include: Any representative of n2n Claims Solutions, The Insured/Policy Owner, my Insurance Policy Broker, my Union/association, my authorised representatives, Employer(s) workers compensation insurer, insurance companies, government department (which includes Centrelink or similar benefit providers), claims assessor, legal firm, accountant, financial advisor, and any physician, hospital, healthcare provider who has attended or examined me, in order for n2n Claims Solutions to be supplied with my full employment, financial and medical history including but not limited to tax returns, any medical or hospital records, reports, clinical notes and referral letters.**

2. **I hereby declare that all information that I've supplied is true and correct in every aspect. I have not made any false or misleading statements.**

3. **I do understand that this claim and any future claims may be refused if any information I've provided is not true, misleading or relevant information has been withheld.**

4. **A photocopy, emailed or faxed version of this Declaration and Authority is considered as effective and valid as the original.**

Name (please print)			
Signature		**Date**	