



Business Insurance

Personal Accident & Illness Claim Form

THE COMPLETION OF THIS FORM AND ITS RECEIPT BY US IS NOT AN INDICATION THAT WE ACCEPT ANY LIABILITY.

PLEASE PRINT IN BLOCK LETTERS and answer all Questions where applicable (Provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

THE FORM SHOULD BE COMPLETED AND RETURNED TO SGIC WITHIN 7 DAYS OF RECEIPT BY THE INSURED.

ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.

Claim No.

Policy No.

Expiry Date

Excess

INSURED'S DETAILS

Name of Insured _____

Address _____

Postcode _____

Telephone No. _____ (Private) _____ (Mobile) _____ (Business)

Contact Name _____ Telephone No. _____ Facsimile No. _____

(1) Are you registered for GST? No Yes

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

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

GENERAL QUESTIONS - To be completed by the Insured

(1) What date was the Insured Person first unable to attend to their usual duties? ____/____/____

(2) How long has the Insured Person been disabled from engaging in or attending to their usual business as the result of the accident/illness?

Totally From ____/____/____ To ____/____/____ **Partially** From ____/____/____ To ____/____/____

(3) Has the Insured Person previously suffered from a similar illness or injury? No Yes

If "yes", please give details including the medical practitioners who provided advice and/or treatment. _____

INSURED PERSON'S DETAILS - To be completed by the Claimant

(1) Name ^{Mr} ^{Mrs} ^{Miss} ^{Ms} _____

Address _____

Postcode _____

Age _____ Occupation _____ Telephone No. _____ Sex Male Female

(2) Have you ever been affected by any illness, disease, physical defect or infirmity? No Yes

If "yes", please give details. _____

(3) Have you required medical or surgical treatment during the past five years? No Yes

If "yes", please give details. _____

(4) Are you entitled to claim from any other insurance policies in respect to this disability? No Yes

If "yes", please give details. _____

ACCIDENTAL INJURY ONLY CLAIM DETAILS

(1) When did the accident happen? Date ____ / ____ / ____ Time ____ am/pm
Where did the accident happen? _____

(2) Describe fully how the accident occurred. _____

(3) Were there any witnesses to the accident? No Yes
If "yes", please give details. Name _____
Address _____

(4) Are you employed? No Yes

(5) Did the injury occur at work? No Yes

(6) Describe nature of injuries sustained by the Insured Person. _____

(7) On what date did the Insured Person first seek medical advice/treatment for the accident? Date ____ / ____ / ____

(8) Please give details of all your treating medical practitioners in relation to the illness. _____

ILLNESS ONLY CLAIM DETAILS

(1) What date did the Insured Person become aware of the illness? ____ / ____ / ____

(2) On what date did the Insured Person **first** seek medical advice/treatment for the illness? ____ / ____ / ____

(3) What date was the Insured Person diagnosed as suffering from the illness? ____ / ____ / ____

(4) Are you employed? No Yes

(5) Did the illness occur through work? No Yes

(6) Describe the nature of the illness. _____

(7) Please give details of all your treating medical practitioners in relation to the illness. _____

DECLARATION AND AUTHORISATION

I/We hereby declare that the foregoing statements are true and correct. I/We consent to the Insurer, in assessing or otherwise dealing with this claim, disclosing my/our personal information to or collecting my/our personal information from related entities, other insurers, insurance reference bureaux, investigators, or other parties providing services to the Insurer.

I/We authorise any Doctor, Hospital, Clinic or other person to give to the Insurer any and all information concerning my current and/or past medical history. A photographic copy of this authorisation shall be as valid as the original.

Name _____ Name _____
Signature _____ Signature _____
Date ____ / ____ / ____ Date ____ / ____ / ____

NOTE: FAILURE TO HAVE THE ATTACHED CERTIFICATE OF MEDICAL PRACTITIONER COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER WILL DELAY THE PROCESSING OF YOUR CLAIM. ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.

DEFINITIONS

Total Disablement

Injury or Illness which results in the claimant being entirely disabled from attending to his/her normal duties, profession, business or occupation.

Partial Disablement

Injury or Illness which results in the claimant being restricted to only attending to part of their normal duties, profession, business or occupation.



Certificate of Medical Practitioner

Business Insurance

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PLEASE ENSURE THIS FORM IS COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER.

ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.

Claim No.

Policy No.

Expiry Date

Excess

MEDICAL PRACTITIONER'S DETAILS

Name ^{Mr} ^{Mrs} ^{Miss} ^{Ms} ^{Other} _____

Address _____ Postcode _____

Qualifications _____

Telephone No. _____ Mobile No. _____ Facsimile No. _____

CLAIMANT'S DETAILS

Name ^{Mr} ^{Mrs} ^{Miss} ^{Ms} _____

Address _____ Postcode _____

(1) State fully the nature of the injuries or diagnosis of illness. (If an eye or limb is involved, state whether left or right)

(2) What are the current symptoms? _____

(3) So far as you are aware, how did the injury arise? _____

(4) Are the injuries sighted consistent with what was conveyed to you as the cause? No Yes
If "no", please give details. _____

(5) Is the claimant suffering from any pre-existing condition which might in any way contribute, aggravate or otherwise impair the person's ability to return to their business, profession or occupation? No Yes
If "yes", please provide details. _____

(6) When did the claimant first consult you in connection with the accident or illness? ____/____/____

(7) Has the claimant previously been treated by you for a similar illness or injury? No Yes
If "yes", please provide details. _____

(8) Are you the claimant's usual Medical Practitioner? No Yes
If "yes", how long have you known the Claimant? Years _____ Months _____

(9) Is the Claimant still under your care? No Yes
If "yes", please provide details of the period of disablement (Refer to the Definitions).
Total From ____/____/____ To ____/____/____ Partial From ____/____/____ To ____/____/____

(10) If disablement, in whole or part, continues - how long is the incapacity likely to continue?
Total From ____/____/____ To ____/____/____ Partial From ____/____/____ To ____/____/____

(11) Any other remarks or comments. _____

MEDICAL PRACTITIONER'S SIGNATURE

Name _____ Signature _____ Date ____/____/____

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