

# Accident/Illness Claim Form



It is essential that this form be returned directly to Ansvar Insurance, with all questions answered, at the earliest opportunity.  
Please print your answers and  where appropriate.

Office use only Claim number

## 1. Policyholder details

Name/Business name	Policy number		
<input type="text"/>	<input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/> <input type="text"/>		
Address	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Date of birth	Telephone: Home	Telephone: Work	Telephone: Mobile
<input type="text"/> / <input type="text"/> / <input type="text"/>	<input type="text"/>	<input type="text"/>	<input type="text"/>
Email	Occupation		
<input type="text"/>	<input type="text"/>		

## 2. Accident/Illness details

Name of claimant	<input type="text"/>		
Address	State	Postcode	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Date of accident/illness	<input type="text"/> / <input type="text"/> / <input type="text"/>	Time	<input type="text"/> am/pm
Description of injury or illness			
<input type="text"/>			
<input type="text"/>			
Describe how and where the accident occurred or illness details			
<input type="text"/>			
<input type="text"/>			

## Was there a witness to the accident?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, name and address of witness</i>	Name	<input type="text"/>		
Address		State	Postcode		
<input type="text"/>		<input type="text"/>	<input type="text"/>		
Telephone: Home	Telephone: Work	Telephone: Mobile			
<input type="text"/>	<input type="text"/>	<input type="text"/>			

## 3. Disablement

Dates of total disablement	From	<input type="text"/> / <input type="text"/> / <input type="text"/>	to	<input type="text"/> / <input type="text"/> / <input type="text"/>
Dates of partial disablement	From	<input type="text"/> / <input type="text"/> / <input type="text"/>	to	<input type="text"/> / <input type="text"/> / <input type="text"/>

## 4. Have you had a similar condition before?

<input type="checkbox"/> Yes <input type="checkbox"/> No	<i>If yes, please give details</i>	<input type="text"/>
<input type="text"/>		

<b>Victoria</b> AD GPO Box 1655 Melbourne 3001 FX +61 3 9614 1545	<b>New South Wales</b> AD PO Box 1410 Parramatta 2124 FX +61 2 9687 9564	<b>Queensland</b> AD GPO Box 747 Brisbane 4001 FX +61 7 3011 8999	<b>South Australia</b> AD PO Box 630 Fullarton 5063 FX +61 8 8338 1920	<b>Western Australia</b> AD PO Box 840 West Perth 6872 FX +61 8 9324 2013	<b>Tasmania</b> AD PO Box 330 Launceston 7250 FX +61 3 9614 1545
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**5. Goods and services tax** To ensure you do not incur any unnecessary GST liabilities on this claim complete these details

Are you registered for GST purposes?  Yes  No What is your ABN?

If you have registered and have an ABN, have you claimed or will you be claiming an input tax credit on the GST applicable to this policy?  Yes  No

Is the amount claimed less than 100% of the GST applicable to the premium?  Yes  No Specify the percentage amount claimed  %

**6. Electronic Funds Transfer** Settlement of your claim may involve a cash settlement. Please complete the following if you are interested in an EFT Payment

Account name  BSB number  Account number

**7. Do you have a personal accident/illness policy with another insurer?**

Yes  No *If yes, name and address of company* Name

Address  State  Postcode

**8. I declare that all the information I have given is true and correct**

Signature  Date  /  /

**Medical certificate**

**Claims must be supported by the medical evidence obtained at your expense. Please have your medical officer complete this section of the form.**

Date that you first attended claimant for the injury/illness  /  /

Will the claimant be prevented from attending work?  Yes  No *If yes, details please*

Totally From  /  /  to  /  /

Partially From  /  /  to  /  /

Is the claimant suffering from any condition which may tend to delay recovery?  Yes  No *If yes, details please*

Please describe the present condition of the claimant

*If insufficient room, use space on back of form or attach separate sheet.*

How long after the accident do you consider: Total disablement will last?

Partial disablement will last?

Having personally examined the claimant I certify that the above statements are correct and that the claimant is disabled by the accident/illness referred to overleaf.

Please print your name

Address  State  Postcode

Signature  Date  /  /

Ansvar Insurance is a member of the insurance industry's impartial Financial Ombudsman Service (FOS). This independent service is provided to the insuring public at no cost and aims to resolve claims complaints quickly and informally. In the unlikely event of a complaint arising, you should firstly contact the local Ansvar Insurance Regional Manager. In most cases the problem will be resolved easily. If you are not satisfied with the response given by the Regional Manager you may contact our Internal Dispute Resolution Committee for advice and assistance in resolving your claim.

**Privacy** The information we collect assists us to make a decision on whether we will accept your claim. If you do not provide this information we may be unable to process your claim. We may use third party suppliers (agents, loss adjusters, assessors and mailing houses) to carry out specialised activities on your behalf. These organisations are aware of their obligations under Privacy provisions. At any time you may request access to your personal information and correct it if it is wrong. We value the personal information you give to us and we will take all reasonable precautions to prevent unauthorised access to this information.