Claim Form

Accident Or Sickness

By furnishing this Form the Company makes no Admission of Liability or Waiver of its Rights. ALL QUESTIONS MUST BE FULLY ANSERED, DASHES ARE NOT ACCEPTABLE	FULL POLICY NUMBER WITH PREFIX

INSURED PERSON'S FULL NAME	STREET ADDRESS	TOWN/CITY	PROVINCE

DATE OF BIRTH	HEIGHT	WEIGHT	SEX	TELEPHONE HOME BUSINESS	

OCCUPATION PRIOR TO DISABLEMENT	DESCRIBE USUAL DUTIES

1. Give full description of injury or sickness for which you are claiming. Attach statement if insufficient space. Give full description of accident giving rise to these injuries including names and addresses of any other parties involved and witnesses.	SICKNESS: Condition ……………………………………………………………………………… When did it commence? …………………………………………………………………………… INJURY: Date of injury…………………………………………………………………………… What were you doing at the time………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… Describe injuries you received………………………………………………………… ……………………………………………………………………………………………… ……………………………………………………………………………………………… WHICH POLICE STATION NOTIFIED………………………………DATE NOTIFIED……………
2. Have you ever had this, or a similar condition, in the past?	IF YES: TICK Conditions……………………………………………………………………………… YES ☐ Dates…………………………………………………………………………………… NO ☐ Treated by…………………………………………………………………………..

3. (a) When did you first consult a doctor for the condition which you are claiming? (b) When did you become totally disabled (unable to work)? (c) If still totally disabled, when do you expect to return to work? (d) If you have returned to work, when were you able to again perform 1. Part of your occupational duties? 2. Al l of your occupational duties?	(a) Date…………………………..Time……………………….a.m. (b) Date…………………………..Time……………………….a.m. (c) Date…………………………..Time……………………….a.m. (d) Date…………………………..Time……………………….a.m. 1. Date…………………………..Time……………………….a.m. 2. Date…………………………..Time……………………….a.m.

4. Hospitals – if you were admitted to hospital, or treated as an out-patient	NAMES	ADDDRESSES	FROM	TO

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please give details- (a) Inpatient (b) Outpatient	(a) (b)	(a) (b)	(a) (b)
5. Give details of all attending Pnysicians.	DOCTOR NAME 1. 2. 3. 4. 5.	ADDRESS 1. 2. 3. 4. 5.	TELEPHONE 1. 2. 3. 4. 5.
6. Who is your usual physician?	NAME	ADDRESS	TELEPHONE
7. What other medical or surgical treatment has been received during the past five years? (Give dates, nature of sickness or injury and names and addresses of all treating doctors,hospitals, and clinics.)	NATURE OF SICKNESS OR INJURY 1. 2. 3. 4. 5.	DOCTOR'S NAME 1. 2. 3. 4. 5.	ADDRESS 1. 2. 3. 4. 5.

8. Are you now, or have you ever been, subject to or affected by any other injury or disease, If so, give details.	
9. Have you ever lodged a Personal Accident or Sickness claim before? If so, give details.	INSUREER………………………………………………………... CLAIM NO…………………………… ADDRESS………………………………………………………………..POLICY NO……………………… DETAILS………………………………………………………………………………………………………..
10.Are you making any other insurance or compensation claim in respect of this disability?	PLEASE ANSWER YES OR NO WORKER'S COMP/WORKCARE………………GOVERNMENT BENEFITS………………………….... MOTOR ACCIDENT LAW………………………SUPERANNUATION LILFE ASSURANCE…………..

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Information Authority And Warranty

I,………..
Hereby authorize any hospital, physician or other person who has attended me, or my employer or my accountant to furnish Alpha Insurance Limited or its representative with:

(i) All copy hospital and medical reports/notes
(ii) All copy employment records and income tax returns; and
(iii) All information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment, employment history and income tax returns.

I agree that a Photostat copy of this authorization shall be considered as effective and valid as the original and specifically authorise it as such.

I declare and warrant that the foregoing particulars are true and correct in every detail and acknowledge that the American Home Assurance Company relies upon the truthfulness of the particulars supplied by me in respect of the claim.

Signed……………………………………………………………………………………Date…………………./………………/20…………………

1. **IF SELF EMPLOYED**
(a) What are your average weekly earnings, net of expenses, but before tax? K………………………………

(b) Do you operate as a Proprietary Ltd Company? □ Yes □ No
(c) Do you or your Company pay Worker's Compensation/Work Care levy? □ Yes □ No

(d) What is your Business Trading Name?...

Address………………………………………………………… Post Code……………………………

Telephone No…………………………………………………Area Code……………………………

Commenced Trading……………………………………………to……………………………………

(e) Who is your Accountant? Name………………………………………………………………………………………………

Address……………………………………………………………………………………………

……………………………………………………………Post Code……………………………………

Telephone No…………………………….……………Area Code……………………………………
(Please submit documentation to validate earnings)

2. **IF EMPLOYED AS A WAGE EARNER TO BE COMPLETED BY YOUR EMPLOYER**

I HERE CERTIFY THAT……………………………………………………………………………..…has been unable to attend to their usual

Occupation with the Company as a result of An Injury/Sickness suffered whilst……………………………………………………………… on……………/……………../……………..
He/She has been incapacitated since………./………./…………….And is expected to/did resume duties on…………/…………/………..

His/her average weekly salary (excluding bonuses, commissions, overtime payments and other allowances) for the 12 months prior to the injury or sickness. K………………………..p.w.

During the period of incapacity K…………………..Normal Pay from………./……………/……….. to ………/…………/………
he/she received K…………………..Sick Pay from………./……………/……….. to ………/…………/………
K…………………..Worker's Compensation from………./……………/……….. to ………/…………/………
K………………… Other (Please Specify) from………./……………/……….. to ………/…………/………
Has been employed since……………/……………/………………

NAME OF COMPANY……

ADDRESS……
SIGNATURE OF SUPERVISOR OR PAYMASTER
………………………………………………………………………………

NAME OF SUPERVISOR OR PAYMASTER (Please print)

………………………………………………………………………………

COMPANY STAMP

TELEPHONE NUMBER……………………………….DATE…………/………………/……………..	

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