

Australian Trainers' Association

Group Personal Accident Insurance Claim Form

Important Information

1. Please complete the Policy and Claimant Details Sections and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully.
3. To avoid delays in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
4. Claims may be subject to an excess as described in your Policy.
5. Please send this form and all documentation to: The Accident & Health Claims Department, Chubb Insurance Australia Limited GPO Box 4065, Sydney, NSW 2001.

A: Policy and Claimant Details (complete for all Claims)

| | | | | | | | |
|---|--|--|----------|-------------|--------|----------|------------------------------|
| Policyholder | Australian Trainers' Association | | | | | | |
| Policy/Certificate Number | 02PO014428 / 02PO014429 | | | Expiry Date | | | |
| Your active level of cover is? | <input type="checkbox"/> Standard Cover (Bronze) <input type="checkbox"/> Advanced Cover (Silver) <input type="checkbox"/> Superior Cover (Gold) | | | | | | |
| Name of Broker who provided the cover | Jardine Lloyd Thompson Pty Ltd | | | | | | |
| Covered Person's Surname | | | | Given Names | | | |
| Home Address | | | | State | | Postcode | |
| Postal Address | (if different from above) | | | State | | Postcode | |
| Phone Numbers: | Private | | Business | | Mobile | | |
| Email Address | | | | | | | |
| Employer's Name | | | | | | | |
| Occupation/s | | | | | | | |
| Date of Birth | | | | | | | |
| What are your gross weekly earnings? | | | | \$ | | | |
| What Benefit are you claiming for? | | | | | | | |
| A) Death/Capital Benefit | | | | | | | <input type="checkbox"/> Yes |
| B1) Routine Duties Benefit | | | | | | | <input type="checkbox"/> Yes |
| B2) Inability to carry out usual Income Earnings Occupation Benefit | | | | | | | <input type="checkbox"/> Yes |
| B3) Injury Resulting in Fractured Bones Benefit | | | | | | | <input type="checkbox"/> Yes |

NB: The Claimant can claim only one (1) of the items under Benefit (B). Please attach invoices or other evidence of expenses you have incurred if the claim is for (B1).

B: Claims for Injury/Including Death

What is the injury?

If injury, how exactly did it occur?

When did the injury occur, or when was it first diagnosed?

Did the injury cause you to stop work? Yes No If Yes, when?

Have you returned to work full-time? Yes No If Yes, when?

Have you returned to work part-time? Yes No If Yes, when?

If Yes, what hours and duties are you currently working?

| Days | Hours | Duties |
|------|-------|--------|
| | | |

Who is your usual family doctor?

Name

Address

Telephone Numbers

When did you first get treatment from a medical practitioner for this condition?

Doctor's Name

Address

Telephone Number

When did you first see the medical practitioner?

Have you consulted another medical practitioner for this condition? If Yes, give details

Yes No

Doctor's Name

Address

Telephone Number

Period

Were you hospitalised? If Yes, give details

Yes No

Hospital Name

Address

Dates of Admission and Discharge

Admission

Discharge

Number of Days in Hospital

During the 24 hours before the injury, did you drink any alcohol or take any drugs other than those prescribed to you by a doctor? If Yes, give details

Yes No

State types & quantities

Have you ever had this or a similar condition in the past? If Yes, give details

Yes No

Date(s)

Treatment received

Name of treating Doctors/Specialists

Addresses of Doctors/Specialist who treated you

C: Other Insurance/Benefits

Are you claiming insurance or compensation from any other insurance company?
eg. Workers Compensation, Traffic Accident Commission, sports body or any income replacement. If Yes, give details below

Yes No

Name of insured organisation/employer & telephone number:

| | | | |
|-----------------|--|-------------------------|--|
| Name of Insurer | | Telephone No. | |
| Type of cover | | Amount claimed per week | |

D: Electronic Funds Transfer Details

Following Chubb approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

| | | | |
|-------------------------------|--|-----------------------|--|
| Name of Financial Institution | | Account Holder's Name | |
| BSB Number | | Account Number | |

E: GST Information

| | |
|---|--|
| a) Are you registered for GST Purposes? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| b) What is your Australian Business Number (ABN)? | |
| c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| d) If Yes, what percentage of the GST did you claim or are you entitled to claim? (if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%) | % |

F: To be completed by your Employer where the Claim is for Item (B2)

If Self Employed please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earnings.

| | | | |
|---|----|------|--|
| Name of Employer | | | |
| This is to certify that | | of | |
| has been unable to attend his/her occupation as a result of Injury from | | to | |
| His/Her average Gross Weekly Salary at the time of this accident was | \$ | | per week |
| He/She has been employed since | | | |
| His/Her Sick Leave Entitlement at the time of this accident was | | | days |
| Has a claim for Worker's Compensation been lodged? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| In the case of a motor vehicle accident, has a claim been lodged against the Traffic Accident Commission? | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Signature of Employer or Supervisor | | | |
| Name of Employer or Supervisor (please print) | | | |
| Telephone Number | | Date | |

G: Chubb Insurance Australia Limited Claim Privacy Consent, Medical Authority and Declaration

Claim Privacy Consent

Chubb Insurance Australia Limited (Chubb) is committed to protecting your privacy. Chubb collects, uses and handles your personal information only in accordance with the Privacy Act 1988 (Cth) (Privacy Act). A copy of our Privacy Policy is available on our website at www.chubb.com/au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by Chubb, or any third party that Chubb provides the information to, for the purpose 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:

- a) any information provided in relation to your claim;
- b) 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 (at any time) or your Health Insurance claims history, including Medicare;
- c) any other personal information that you may provide to Chubb or its third party contractors;
- d) any information relating to any insurance policy on your life, including terms and conditions and claims history;
- e) details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
- f) any other information relating to your income, assets, liabilities and solvency; and
- g) 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 assess and process your claim Chubb may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example, social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant or investigator retained by Chubb, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

Chubb may disclose your personal information, including health and sensitive information, to other entities within the Chubb Group, other insurers, our reinsurers or third parties, including contractors and contracted service providers (such as assessors or investigators) who we, or those other Chubb Group entities, have engaged to provide a specific service. Those entities may be located overseas, for example the regional head offices of Chubb in Singapore, UK or USA or third parties with whom we or those other Chubb Group entities have subcontracted to provide a specific service for us, which may be located outside of Australia (such as in the Philippines or USA).

Chubb may also disclose your personal information to witnesses in respect to your claim and to government agencies including the police (where we are compelled to by law).

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, Chubb may not be able to process or assess 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 customer relations team on 1800 815 675 or email CustomerService.AUNZ@chubb.com.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, Chubb has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Chubb using and disclosing my personal information pursuant to Chubb's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Chubb's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to Chubb such personal information (including health information) as Chubb in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits. I will use my best endeavours and render all reasonable assistance and co-operation to Chubb in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim. I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint Chubb to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

| | | | |
|-----------------------|--|------|--|
| Signature of Claimant | | | |
| Name of Claimant | | Date | |
| Signature of Witness | | | |
| Name of Witness | | Date | |

Medical Practitioner's Statement to Company

The Policyholder is responsible for any fee for this statement.
This form should be completed and returned to Chubb promptly.

| | | | | | |
|---|-------------------|------------------|-------------------|---------------|--|
| Patient's Full Name | | | | | |
| Height | cms | Weight | kgs | Date of Birth | |
| Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound) | | | | | |
| Cause: | | | | | |
| If available please provide a copy of X-ray report | | | | | |
| Is this condition an injury <input type="checkbox"/> or an illness <input type="checkbox"/> | | | | | |
| Does the patient have any other injury or illness that is contributing to the condition? eg: Osteoporosis | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, give details | | | | | |
| Is condition due to injury or sickness arising out of the patient's employment? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, give details | | | | | |
| Was the disability sports related? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, give details | | | | | |
| Date of onset/first symptoms? | | | | | |
| When did the patient first consult you for this condition? | | | | | |
| Has the patient ever had the same or similar condition? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, give details | | | | | |
| How long have you been the patient's usual doctor/medical practice? | | | years | | |
| Has the patient been hospitalised? | Date of Admission | | Date of Discharge | | |
| Name of Hospital | | | | | |
| Name of patient's usual doctor/medical practice | | | | | |
| Has the patient had surgery or is it anticipated? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, give details | | | | | |
| Date performed or anticipated | | Name of hospital | | | |
| Did you provide other medical services (including pathology) to the patient? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| If Yes, itemise, date, give details | Date: | | | | |
| | Date: | | | | |
| Was the patient referred by you or to you? | | | | | <input type="checkbox"/> Yes <input type="checkbox"/> No |
| Please provide: | | | | | |
| Name of referring doctor | | | | | |
| Address of referring doctor | | | | | |
| Date of referral | | | | | |

| | | | | | | |
|--------------------------------|---|--------------------------------------|------|--|----|--|
| Is the patient still disabled? | <input type="checkbox"/> No | when did the patient return to work? | | | | |
| | <input type="checkbox"/> Yes | how long will the patient be: | | | | |
| | Totally Disabled (unable to perform any part of their occupation) | | from | | to | |
| | Partially Disabled (able to perform part of their occupation) | | from | | to | |

If partially disabled, what duties could the patient perform and for how many hours a week?

| | |
|----------------|--|
| Hours per week | |
|----------------|--|

| | |
|---|--|
| Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body? | <input type="checkbox"/> Yes <input type="checkbox"/> No |
|---|--|

If Yes, give details:

| | |
|-----------------|--|
| Name of Company | |
| Claim No. | |
| Contact Name | |
| Telephone No. | |

Remarks:

| | | | |
|-----------------------------------|--|------|--|
| Signature of medical practitioner | | | |
| Name | | Date | |
| Qualifications | | | |
| Address | | | |
| Telephone Number | | | |

About Chubb in Australia

Chubb is the world's largest publicly traded property and casualty insurance company. With operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients. As an underwriting company, we assess, assume and manage risk with insight and discipline. We service and pay our claims fairly and promptly. The company is also defined by its extensive product and service offerings, broad distribution capabilities, exceptional financial strength and local operations globally. Parent company Chubb Limited is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index. Chubb maintains executive offices in Zurich, New York, London and other locations, and employs approximately 31,000 people worldwide.

Chubb, via acquisitions by its predecessor companies, has been present in Australia for over 50 years. Its operation in Australia (Chubb Insurance Australia Limited) provides specialised and customised coverages, including Marine, Property, Liability, Energy, Professional Indemnity, Directors & Officers, Financial Lines, Utilities, as well as Accident & Health insurance, to a broad client base. Chubb is a major insurer of many of the country's largest companies. With five branches and over 500 staff in Australia, it has a wealth of local expertise backed by its global reach and breadth of resources.

More information can be found at www.chubb.com/au

Contact Us

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