CHUBB®

Personal Injury

Claim Form

Send Claim To:

Chubb Insurance Australia Limited
GPO Box 4065, Sydney NSW 2001 Australia

O 1800 688 640 Claims
O 1800 815 675 Customer Service
F +61 2 9231 3697
E A&HClaims.AU@chubb.com

Important Information

1. Please complete the Policy Details Section 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 delay 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 email this form and all documentation to: A&HClaims.AU@chubb.com
6. Please send this form and all documentation to:
   The Accident & Health Claims Department, Chubb Insurance Australia Limited GPO Box 4065, Sydney, NSW 2001.

It is important you provide honest, complete, up-to-date and relevant information when completing this form.

Section 1: Policy and Claimant Details

Policyholder - Claimant ☐ Other ■	Given Name	Mr/Mrs/Miss/Ms	Anglican Insurance & Risk Services incl				
Policy/Certificate Number	04PO009199			Expiry Date	31/10/24		
Name of Broker who provided the cover	AIRS via Victor						
Surname		First Names					
Home Address				State		Postcode	
Postal Address	(if different from above)			State		Postcode	
Phone Numbers:	Private		Business		Mobile		
Email Address							
Employer's Name							
Occupation							
Usual Duties				Date of Birth			
What are your gross weekly earnings? $							
Who are you claiming for?	Self ☐	Spouse/Partner ☐	Spouse/Partner ☐	Given name			

What are you claiming for? (e.g. Temporary Total Disablement)

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:

Australian Bank Account Details

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

GST Information (For Australian Claims Only)

a) Are you registered for GST Purposes?	☐ Yes ☐ 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?	☐ Yes ☐ 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%)	%

Section 2 - Claims for Injury/Illness/Death

What is the injury or illness?	

If injury, how exactly did it occur?	i.e. playing sport, etc.

When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed?			
Did the injury or illness 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 working?

Days		Hours		Duties	

Is this condition due to injury or sickness arising out of your employment?	☐ Yes ☐ No
If Yes, give details	
If Injury, how exactly did it occur?	

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	

Have you consulted any other medical practitioner for this condition? If Yes, give details				☐ Yes ☐ No
Doctor's Name				
Address				
Telephone Number		Period		
Did you go to hospital? 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? 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				
What other significant medical or surgical treatment have you received in the past 5 years? Please give details below				
Date(s)				
Nature of the condition(s) treated				
Name of treating Doctors/Specialists				
Addresses of Doctors/Specialist who treated you				
Are you affected by any other long term or chronic disability? If Yes, give details				☐ Yes ☐ No

Section 3 - Claims for additional Benefits for Injury or Illness

Not all Policies provide these Benefits. Please only complete if applicable

Are you claiming for:

- homecare or income replacement after major surgery for cancer
- childminding or income replacement after a child's accident
- home tuition fees after a child's accident
- medical expenses not covered by Medicare
- damage to personal property

Give details, specifying each item

Item	Amount
	A$
	A$
	A$
	A$

Please attach invoices or other evidence of the expenses you have incurred or receipts for damaged property.

Section 4 - 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	
Do you have private health insurance?	☐ Yes ☐ No	If Yes, give details	
Do you have ambulance cover?	☐ Yes ☐ No	If Yes, give details	

Section 5 - To be Completed by Your Employer

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 or Sickness from		to	
His/Her average Gross Weekly Salary at the time of this accident/sickness was	A$		per week
He/She has been employed since			
His/Her Sick Leave Entitlement at the time of this accident/sickness was			days
Has a claim for Worker's Compensation been lodged			☐ Yes ☐ No
In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission?			☐ Yes ☐ No
Signature of Employer or Supervisor			
Name of Employer or Supervisor (please print)			
Telephone Number		Date	

Section 6 - 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	

Section 7 - 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 ☐ or an illness or an illness ☐					
Does the patient have any other injury or illness that is contributing to the condition? eg: Osteoporosis					☐ Yes ☐ No
If Yes, give details					
Is condition due to injury or sickness arising out of the patient's employment?					☐ Yes ☐ No
If Yes, give details					
Was the disability sports related?					☐ Yes ☐ 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?					☐ Yes ☐ 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?					☐ Yes ☐ No
If Yes, give details					
Date performed or anticipated		Name of hospital			
Did you provide other medical services (including pathology) to the patient?					☐ Yes ☐ No
If Yes, itemise, date, give details					
Was the patient referred by you or to you?					☐ Yes ☐ No
Please provide:					
Name of referring doctor					
Address of referring doctor					
Date of referral					

Section 7 - Medical Practitioner's Statement to Company (Continued)

Is the patient still disabled?	☐ No	when did the patient return to work?				
	☐ 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?	☐ Yes ☐ No
If Yes, give details:	
Name of Company and Claim No.	
Contact Name and Telephone No.	
Remarks:	

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

To Be Completed by the Insured for all Claims on Group Personal Injury and/or Sickness Policies

I,			
confirm that			
is an Employee/Member/Volunteer Worker/Other (Please Specify)			
of (company name)			
and that he/she is eligible to claim for the Injury/Illness occurring on			
Signature		Name	
Title		Contact Number	
Claim Reference (if known)			
Policy Number (if known)			

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

Chubb Insurance Australia Limited
ABN: 23 001 642 020 AFSL: 239687

Grosvenor Place
Level 38, 225 George Street
Sydney NSW 2000
O +61 2 9335 3200
F +61 2 9335 3411
www.chubb.com/au

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