personal **accident claim form**

HIGH STREET
UNDERWRITING AGENCY

hsua.com.au
A.C.N 096 939 169 AFS License 244370

Version: 2.0.

instructions

1. You must fully complete Sections 1 - 5 of the claim form, including either the illness or injury statement. We cannot proceed with the claim without this information.
2. Ensure you sign the "Medical Authority Declaration" (Section 6).
3. **YOUR EMPLOYER** fully completes "Employers Incident Report" of the claim form (Section 7).
4. **YOUR DOCTOR** fully completes the two page "Medical Practitioners Statement" (Section 8).
5. Attach a copy of your most recent Payslip to your claim submission.
6. Scan and email the claim form through to info@hsua.com.au

important information

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
3. The issue of this form is not an admission of liability.

High Street Underwriting Agency Pty Limited A.C.N 096 939 169 AFS Licence 244370 (High Street) is a member of the Underwriting Agencies Council (UAC). High Street is an authorised Coverholder of Certain Underwriters at Lloyd's and is licenced to wholesale insurance in Australia.

High Street Underwriting Agency uses Corporate Services Network to manage all Personal Accident & Illness claims.

The Insured or any person entitled to claim under this Policy must give Corporate Services Network ('CSN') written notice of any event which is likely to give rise to a claim, within thirty (30) days, or as soon as is reasonably practicable.

section 1

employer **and policy information**

1.1. Please provide your Employer Name and their Policy Number. (Ask your employer for this.)

Employer:

Policy Number:

your **details**

1.2.1. Given Name/s:

1.2.2. Family Name:

1.2.3. Date of Birth:

1.2.4. Gender:

1.2.5. Email:

1.2.6. Daytime Phone:

1.2.7. Alt. Phone:

1.2.8. Address:

1.3. Occupation:

1.4. Worksite / Location:

section 2

eft **authorisation**

2.1. I hereby authorise and request that Corporate Services Network to credit my bank account as indicated below:

Account Name:

Account Bank:

BSB (6-Digits):

Account Number:

section 3

incident **details**

3.1. Date of Incident:

3.2. Time of Day:

3.3. Incident Address:

3.4.1. Were there any witnesses to the incident? ○ Yes, Go to 3.4.2. ○ No, Skip to 3.5.

3.4.2. Witness Name:

3.4.3. Witness Address:

3.5. Please tell us about the incident:

3.6. Please tell us what injuries were sustained:

3.7.1. Have you previously been treated from a similar or same injury? ○ Yes, Go to 3.7.2. ○ No, Skip to 3.8.1.

3.7.2. Please provide more details about regards to previous treatment:

3.7.3. Please provide details of any claim made for any previous injury against any insurance company:
(Use the Additional Information page at the end of the document if more space is required.)

3.8.1. During the 24 hours before the injury, did you drink any alcohol or take any drugs? ○ Yes, Go to 3.8.2. ○ No, Skip to 4.1.

3.8.2. Please provide information on how much, the types and at what time:

section 4

You only need to complete Section 4 if your disability is as a result of an illness / sickness.

disability **details**

4.1. Incident Address:

4.2. When Illness Began:

4.3.1. Have you had this illness before? ○ Yes, Go to 4.3.2. ○ No, Skip to 4.4.

4.3.2. When did you have this illness:

4.3.3. How long were you disabled for?

section 5

treatment **received**

5.1. Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

5.2. When did you stop work? (Date and Time)

5.3. When did you first receive treatment? (Date and Time)

5.4.1. Current Treating Doctor:

5.4.2. Treating Doctor / Clinic Address:

5.5.1. Regular Doctor Name:

5.5.2. Regular Doctor Address:

5.6.1. First Consulted Doctor:

5.6.2. Last Consulted Doctor

5.5.1. How long have you you known this Doctor? years months

If you have known your Doctor for more than 5 years, you can skip to 5.8.1.

If you have not seen the above Doctor for more than 5 years or have visited other than this Doctor, please provide the Doctors information for the past 5 years (If this is not completed, it may delay your claim):

5.6.1. Doctor 1 Name:

5.6.2. Doctor 1 Address:

5.6.3. First Consulted Doctor 1:

5.6.4. Last Consulted Doctor 1:

5.6.5. How long have you you known Doctor 1? years months

5.7.1. Doctor 2 Name:

5.7.2. Doctor 2 Address:

5.7.3. First Consulted Doctor 2:

5.7.4. Last Consulted Doctor 2:

5.7.5. How long have you you known Doctor 2? years months

5.8.1. Was hospital treatment required?

- ○ Yes, Go to 5.8.2.
- ○ No, Skip to 5.9.1.

5.8.2. If "**Yes**" to 5.8.1., please complete the following regarding your Hospital Stay (please use the "Additional Info" page at the end of the document if insufficient space)

from	to	hospital name	hospital address

5.8.4. Please provide details of all attending physicians:

doctor name	address	phone

5.9.1. Is there any condition (past or present) affecting your current disability?

- ○ Yes, Go to 5.9.2.
- ○ No, Skip to 5.10.1.

5.9.2. If "**Yes**" to 5.9.1., please provide details below:

5.10. Are You...

5.10.1. Now recovered?
- ○ Yes, Go to 5.10.2.
- ○ No, Go to 5.11.1.

5.10.2. When did you return to work?

5.11.1. Partially disabled?
- ○ Yes, Go to 5.11.2.
- ○ No, Go to 5.12.1.

5.11.2. When did you return to work undertaking part of?

5.12.1. Totally disabled?
- ○ Yes, Go to 5.12.2.
- ○ No, Go to 5.13.1.

5.12.2. When do you expect to return to work?

5.13.1. Have you made, or will you make, or are you entitled to make , a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury?

- ○ Yes, Go to 5.13.2.
- ○ No, Skip to 5.14.1.

5.13.2. If "**Yes**" to 5.13.1., please provide details below:

	claim number	name	address
Employer			
Worker Comp / Transport			

5.14.1. Name of your Superfund:

5.14.2. Superfund Membership Number:

5.14.3. Are you entitled to Income Protection Benefits through your Superfund?

- ○ Yes, Go to 5.14.4.
- ○ No, Skip to 5.15.1.

5.14.4. If "**Yes**" to 5.14.3., please provide your Claim Reference Number:

5.15.1. Are you entitled to claim benefits for this Injury / Illness from other Insurers (i.e. Personal Income Protection Insurance), Persons, Company, Health Fund, Friendly Society or Government?

- ○ Yes, Go to 5.15.2.
- ○ No, Skip to Section 6.

5.15.2. If "**Yes**" to 5.15.1., please provide details of the provider/s:

name	address

section 6

corporate **services network**

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.csnet.com.au and send to privacy@csnet.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting +612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

medical **authority and declaration**

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

I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN'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 CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN 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 cooperation to CSN 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 if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.

I appoint CSN 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.

Signed: _____ Full Name: _____

Date: _____

section 7

employers **incident report**

7.1. Employer Name:

7.2. This is to Certify that: has been unable to attend his/her occupation as a result of Injury or Sickness.

7.3. Injured From:

7.4. Injured To:

7.5. His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was:

AUD$

7.6. Employee's Occupation:

7.6. Type of Employment: ○ Permanent Full Time ○ Permanent Part Time ○ Casual ○ Fixed Term/ Contract

7.7.1. Are they still employed: ○ Yes, Skip to 7.8. ○ No, Go to 7.7.2.

7.7.2. Last date they were employed:

7.8. Sick leave entitlement as at the date of the incident:

7.9. Employed since (Start Date):

7.10. Has a claim for Worker's Compensation been lodged? ○ Yes ○ No

7.11. In the case of a Motor Vehicle accident, has a claim been lodged against the Traffic Accident Commission / CTP? ○ Yes ○ No

The below must be completed by a Supervisor or Manager.

Signed: Full Name:

Contact Phone Date:

section 8

medical **practitioner report**

8.1. Patients Name:

8.2. Date of Birth:

8.3. Height:

8.4. Weight:

8.5. Diagnosis (if a fracture or dislocation, describe nature and location i.e. Simple, Compound)

8.6. Cause of Injury

8.7. Is this condition:

- ○ An Injury
- ○ An Illness

8.7.1. Does the patient have any other injury or illness that is contributing to the condition?

- ○ Yes, Go to 8.7.2.
- ○ No, Skip to 8.8.1.

8.7.2. If "**Yes**" to 8.7.1., please provide details

8.8.1. Is the condition due to injury or sickness arising out of the patient's employment?

- ○ Yes, Go to 8.8.2.
- ○ No, Skip to 8.9.1.

8.8.2. If "**Yes**" to 8.8.1., please provide details

8.9.1. Was the disability sports related? ○ Yes, Go to 8.9.2. ○ No, Skip to 8.10.

8.9.2. If "**Yes**" to 8.9.1., please provide details

8.10. Date of onset / first symptoms:

8.11. When did the patient first consult you for this condition?

8.12.1. Has the patient ever had the same or similar condition? ○ Yes, Go to 8.12.2. ○ No, Skip to 8.13.

8.12.2. If "**Yes**" to 8.12.1., please provide details on when and the diagnosis:

8.13.1. Doctor / Clinic Name:

8.13.2. How long have you been the patient's usual Doctor / Medical Practice?

8.14.1. Has the patient been hospitalised? ○ Yes, Go to 8.14.2. ○ No, Skip to 8.15.1.

8.14.2. Hospital Name:

8.14.3. Admission Date: 8.14.4. Discharge Date:

8.15.1. Has the patient had surgery or is it anticipated? ○ Yes, Go to 8.15.2. ○ No, Skip to 8.16.1.

8.15.2. If "**Yes**" to 8.15.1., please provide details:

8.15.3. Hospital Name:

8.15.4. Date performed or anticipated:

8.15.5. Please outline all treatment received to date in the management of your patient's condition. Please include any relevant medical documents, reports or investigative scans.

8.16.1. Was the patient referred by you or to you? ○ Yes, Go to 8.16.2. ○ No, Skip to 8.17.1.

8.16.2. If "**Yes**" to 8.16.1., please provide details of the referral:

8.16.3. Referring Doctor Name:

8.16.4. Date of Referral:

8.17.1. Is the patient still disabled? ○ Yes, Go to 8.17.3. ○ No, Go to 8.17.2.

8.17.2. When did the patient return to work?

8.17.3. How long will the patient be totally disabled? (Unable to return to work until)

8.17.4. How long will the patient be partially disabled? (Able to return to work to perform some duties)

8.18.1. Was the patient referred by you or to you? ○ Yes, Go to 8.18.2. ○ No, Skip to 8.19.

8.18.2. Name of Company:

8.18.3. Contact Name:

8.18.4. Claim Number:

The below must be signed by your Doctor.

8.19. Signed: Date:

Name and Qualifications:

Address:

Phone:

what **to do**

1. Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employers and Medical Practitioner have signed this form.
2. Send this form to:
   Corporate Services Network
   GPO BOX 4276, Sydney NSW 2001
   Fax (+61)2 8256 1775
   Email to claims@csnet.com.au

disputes

Corporate Services Network has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.

Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.

If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access to the applicable insurer's Internal Dispute Resolution Committee who can review Your complaint.

If Your complaint is not resolved in a manner satisfactory to You, You may refer the matter to Australian Financial Complaints Authority (AFCA).

AFCA can be contacted by post GPO Box 3, Melbourne VIC 3001, phone 1800 931 678 or email info@afca.org.au. More information can be found on their website www.afca.org.au.

AFCA is an independent body that operates nationally in Australia and aims to resolve disputes between You and Your Insurer. AFCA provides fair and independent financial services complaint resolution that is free to consumers. Determinations made by AFCA are binding upon Us.

Your dispute must be referred to AFCA within 2 years of the date of Our final decision.

additional **information**

info@hsua.com.au
1800 096 829
hsua.com.au

PO Box 7174, Brendale QLD 4500
1/3 Hinkler Court, Brendale QLD 4500

A.C.N. 096 939 169 | AFS License 244370