# ACCIDENT & SICKNESS CLAIM FORM

This form should be completed and forwarded to -
**Echelon Claims Services, GPO Box 1693 Adelaide SA 5001**

For any queries on the completion of this form -
**Please contact Echelon Claims Services on Ph (08) 8235 6455 or Free call 1800 640 009**

**EVERY QUESTION MUST BE COMPLETED**

**JLT (CSI) Discretionary Trust Arrangement**

## Important

We act upon your claim as soon as we receive this form. You can help us in the assessment of your claim, if you:

1. Complete this form in full. Supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents as indicated may result in a delay in processing your claim.
2. Provide a comprehensive description of the circumstances of the Accident/Injury or the Sickness.
3. If this claim form does not provide enough space, please use a separate piece of paper and attach as supplementary information.
4. When all information has been completed, please forward the claim form to Echelon Claims Services.

## Personal Statement

| | | |
|---|---|---|
| Claimant Name: | | |
| Postal Address: | | |
| Contact Details: | Work No: | Home Telephone: |
| Mobile No: | Facsimile | E-mail: |
| Personal Information: | Height: | Weight: |
| | Date of Birth: | |
| Usual occupation: | | |
| Employer's Name: | | |
| Location/Department: | | |
| Employer's Telephone No: | | |
| Gross Weekly salary/income (before tax) $ | | |

## Summary of Claim

| | | | |
|---|---|---|---|
| I am claiming the following benefits under this Insurance: | | | |
| Lump Sum Benefits | | | Amount $ |
| Weekly Benefits | Period | To | Amount $ |
| Other (please specify) | | | Amount $ |
| | | **Total** | **Amount $** |

## Statement of Claim

**To be completed by the Claimant**

| | | |
|---|---|---|
| 1. | When did the accident occur or when did you first become aware of your sickness? | |
| | Date: | Time: am/pm |
| 2. | What was the first day you were unable to attend work? Date: | |
| 3. | What medical practitioner(s) did you consult? | |
| | Name: | Date of visit: |
| | Name: | Date of visit: |
| | Name and address of your USUAL Doctor (family General Practitioner): | |
| | Name: | Telephone No: |
| | Address: | |
| 4. | In your own words, please describe the Injury or Sickness | |
| | | |
| | | |
| | Please describe exactly what you were doing at the time of your Injury/Sickness and how it happened: | |
| | | |
| | | |
| | Where did the Injury or Sickness occur? | |
| | | |
| | Please state when you first became aware of symptoms before consulting your GP or Specialist - | |
| | | |
| | If your condition is a result of an accident, state whether the accident happened at work, in a road accident or whilst travelling to or from work or other - | |
| | | |

| | | | |
|---|---|---|---|
| | Were the police in attendance as a result of this accident? | Yes ☐ | No ☐ |
| | If so, please provide a copy of their report or the attending officer's name and police station. | | |
| 5. | Name and address of witness: | | |
| | | | |
| 6. | Was hospitalisation required? | Yes ☐ | No ☐ |
| | Was the use of an ambulance required? | Yes ☐ | No ☐ |
| | Name of hospital: | | |
| | Dates confined: | From: | To: |
| 7. | Have you ever suffered from this or a similar condition in the past? | Yes ☐ | No ☐ |
| | If YES, please give details and dates: | | |
| | | | |
| | | | |
| 8. | During the 24 hours before the injury, did you consume alcohol or drugs? | Yes ☐ | No ☐ |
| | If YES, please state type and what quantities - | | |
| | Type: | Quantity: | |
| 9. | Are you making, or are you entitled to make a claim in respect of this injury or sickness for any of the following? | | |
| | If YES, please provide details (and dates where applicable) : | | |

| | **Benefit** | | **Details** |
|---|---|---|---|
| | Sick Leave | Yes/No | |
| | Third Party Insurance | Yes/No | |
| | Other Insurance | Yes/No | |
| | Centrelink Benefits | Yes/No | |
| | Workers' Compensation | Yes/No | |
| | Other Government Benefit | Yes/No | |

| | | | |
|---|---|---|---|
| 10. | When did you, or when do you expect to resume work? | Date: | |
| | Please provide your reasons explaining why you are unable to carry out your usual duties: | | |
| | | | |
| | | | |
| | Do you consider yourself fit for alternative duties? | Yes ☐ | No ☐ |
| | If YES, have you discussed the possibility with your Employer and if so, what was the outcome? | | |
| | | | |

| | | | |
|---|---|---|---|
| 11. | Have you engaged in any other income earning employment since you became disabled? | Yes ☐ | No ☐ |
| | If YES, please provide details: | | |
| | | | |
| 12. | Have you ever made a previous claim in respect to Accident or Sickness Insurance? | Yes ☐ | No ☐ |
| | If YES, please provide details: | | |
| | | | |

## CLAIMANT DECLARATIONS & MEDICAL AUTHORISATIONS

| | |
|---|---|
| 1. | I,_____solemnly and sincerely DECLARE that the information given by me in this claim is true and complete. |
| 2. | I UNDERSTAND that the claim may be declined if the information supplied is untrue and I have not revealed all relevant facts. |
| 3. | I AGREE to supply any further information that may be requested of me in connection with my claim. |
| 4. | I AUTHORISE any Doctor, Dentist, Physiotherapist, Company, Firm or Person to disclose to Jardine Lloyd Thompson Pty Ltd any and all information that they may request in connection with this claim. |
| 5. | My Medicare number is: |
| 6. | I AGREE that a photocopy of this Authorisation shall be considered to be effective and valid as the original. |
| 7. | I have read and accept the Privacy Collection Statement provided with this claim form. |

## Banking Details

**BSB:** _____

**Account Number:** _____

**Account Name:** _____

**Email Address:** _____

**Signature of Claimant:** _____ **Dated:**

| Income Details – (delete whichever is not applicable) | | |
|---|---|---|
| **1.** | **IF SELF EMPLOYED** | |
| | If the claimant is not an employee (i.e. a self employed contractor) then the gross weekly income derived from personal exertion in their usual occupation, after deducting any expenses necessarily incurred in deriving that income, averaged over the number of weeks so engaged during the twelve (12) months immediately preceding the date of disablement giving rise to claim, **must be supplied.** | |
| | Your Accountant's Name: | |
| | Address: | |
| | Telephone No: | |
| | Please confirm employment/position status (i.e. Director / Partner / Sole Trade/ Other): | |
| **2.** | **IF EMPLOYED AS A WAGE EARNER, TO BE COMPLETED BY YOUR EMPLOYER** | |
| | I hereby certify that _____ has been unable to attend their usual occupation with the Company as a result of an Injury/Injuries/Sickness suffered on _____. | |
| (a) | What was the employee's last day at work? | |
| (b) | When is the employee expected to / did resume duties? | |
| (c) | If the claimant is an Employee, please complete the attached **Declaration of Pre-Disability Earning Form** to confirm earnings across the number of weeks so engaged during the fourteen (14) weeks immediately preceding the date of disablement giving rise to this claim. | |
| (d) | When did the claimant commence employment with the Company / / | |
| (e) | Please describe the claimant's usual occupation listing details of primary responsibilities - | |
| | | |
| (f) | Has the employee lodged or intend lodging a Workers' Compensation claim? Yes ☐ No ☐ | |
| | If YES, please provide copy of confirmation of acceptance or rejection (letter) from the Insurer. | |
| (g) | Is there any additional information you would like to provide in relation to the submission of this claim? | |
| | | |

| | | |
|---|---|---|
| Name of Company: | | |
| Postal Address: | | |
| Signature of Supervisor or Paymaster: | | Dated: |
| Name of Supervisor or Paymaster:<br>(please print) | | Dated |
| Telephone No: | Facsimile No: | E-mail: |

| Declaration of Pre-Disability Earnings |
|---|
| **Weekly earnings during the 14 weeks prior to incapacity – <u>for employees</u>** |
| **Worker's Name:** |
| **Please read the following definition of "Ordinary Time Earnings" before completing this form.** |
| "Ordinary Time Earnings" means, the actual ordinary hourly rate of pay the employee receives for ordinary hours of work including, but not limited to, superannuation and redundancy fund allowance, tool allowance, industry allowance, trade allowances, shift loading, special rates, qualification allowances, (eg. first aid, laser safety officer), multi-story allowance, site allowance, asbestos eradication allowance, leading hand allowances, in charge of plant allowance, supervisory allowances and all other allowances applicable. Ordinary Time Earnings includes the base hourly rate of pay as set out in Schedule 2 of the EBA plus all-purpose allowances and any regular over Award payments, as well as, casual rates and any additional rates and allowances paid for work undertaken during ordinary hours of work, including fares and travel. |

| | Week Ending – DD/MM/YY | Gross Weekly Earnings as noted above + overtime (if applicable) |
|---|---|---|
| 1 | | $ |
| 2 | | $ |
| 3 | | $ |
| 4 | | $ |
| 5 | | $ |
| 6 | | $ |
| 7 | | $ |
| 8 | | $ |
| 9 | | $ |
| 10 | | $ |
| 11 | | $ |
| 12 | | $ |
| 13 | | $ |
| 14 | | $ |
| | **TOTAL** | **$** |
| | **Average Weekly** | **$** |

Earnings during the fourteen (14) weeks prior to disablement must be provided. (Please note if cover is provided on a site specific basis, then only the earnings in relation to that site should be provided).

To avoid delays, please ensure that this form is fully completed with ALL "Ordinary Time Earnings" as detailed in definition above. Please note that Weekly Benefit entitlements will be calculated upon the information/declaration that you provide.

I sincerely DECLARE that to the best of my knowledge the information provided above is true, accurate and complete.

| | |
|---|---|
| **Payroll Officer's Name:** | |
| **Signature:** | **Dated**: |

| Doctor's Statement | | | | |
|---|---|---|---|---|
| **IMPORTANT: LEASE PRINT LEGIBLY – THIS FORM CANNOT BE ACCEPTED OTHERWISE** | | | | |
| 1. | The patient is responsible for any fee for this statement. | | | |
| 2. | This form can only be completed by the Treating Medical Practitioner or Surgeon (not Physiotherapist). | | | |
| 3. | Dashes or blank spaces are not acceptable. | | | |
| 4. | If the regular or usual doctor was not the treating doctor, this statement will also have to be completed by the claimant's regular doctor. If the claimant has been referred to another physician for treatment, a subsequent statement may be required to be completed by that physician. | | | |
| **Claimant's Full Name:** | | | | |
| 1. | How many years or months has the claimant been your patient / under your care? | | | |
| 2. | (a) | What date were you first consulted by the claimant in connection with the present Sickness or Accident?<br>Date: | | |
| | (b) | How long had the patient been experiencing symptoms prior to consulting you for the first time? | | |
| | | | | |
| | (c) | Are these symptoms consistent with the current diagnosis? | | |
| | (d) | When do you believe this condition first manifested? | | |
| 3. | (a) | What is the exact nature of the present Sickness or Injury? | | |
| | | | | |
| | | | | |
| | (b) | If X-Ray examination or other tests have been made, state finding and/or quote report. | | |
| | | | | |
| | (c) | What is the (proximate) cause of the disabling condition? | | |
| | | | | |
| 4. | (a) | Is the current condition in any way related to their work? | Yes ☐ | No ☐ |
| | (b) | Would you support a Workers' Compensation claim? | Yes ☐ | No ☐ |
| | | If not, please explain why not - | | |
| | | | | |
| 5. | Has the patient previously suffered from the same or a similar condition? | | Yes ☐ | No ☐ |
| | (a) | Dates of consultations: | | |
| | (b) | Diagnosis: | | |
| | (c) | Was this occurrence/recurrence expected? | Yes ☐ | No ☐ |

| | | |
|---|---|---|
| | If so, why? | |
| | | |
| | (d) Do you expect any further recurrence of this condition? | Yes ☐ No ☐ |
| | If YES, please provide details: | |
| | | |
| | | |
| 6. | Is there anything in the patient's medical history that may have contributed or aggravated, either directly or indirectly to the Injury/ Sickness? | Yes ☐ No ☐ |
| | If YES, please provide details: | |
| | | |
| | | |
| 7. | Is there anything in the patient's medical history that may be likely to delay the recovery? | Yes ☐ No ☐ |
| | If YES, please provide details and advise how long recovery may be delayed: | |
| | | |
| | | |
| 8. | Please provide summary details of all past and present medical advice and treatment provided to the patient in respect of his/her current disablement: | |
| | | |
| | | |
| 9. | Do you consider treatment other than that being received is essential to recovery? | Yes ☐ No ☐ |
| | If YES, please provide details. How might this promote a return to work? | |
| | | |
| | | |
| 10. | Have you referred the patient to other specialist services or treatment? | Yes ☐ No ☐ |
| | If YES, please provide details and a telephone contact number - | |
| | | |
| | | |
| 11. | If the claimant has already been hospitalised, please give name of hospital and dates. | |
| | | |

| | | | |
|---|---|---|---|
| 12. | Is treatment likely to be prolonged by any complications? | | Yes ☐ No ☐ |
| | If YES, please provide details and advise how long treatment may be prolonged: | | |
| | | | |
| 13. | Has the claimant continued to follow medical advice? | Yes ☐ | No ☐ |
| | If NO, please provide details: | | |
| | | | |
| 14. | Is there any reason or evidence to suggest the patient was under the influence of intoxicants at the time of the accident or that intoxicants may have caused the injury? | Yes ☐ | No ☐ |
| 15. | (a) When was the claimant obliged to cease work? | | |
| | (b) When did or when do you realistically expect the claimant to resume work? | | Date: |
| | (i) Full unrestricted duties: | | Date: |
| | (ii) Modified duties, if necessary: | | Date: |
| | (iii) Normal duties in reduced capacity (i.e. restricted hours): | | Date: |
| | If unable to return to work in a partial capacity, please provide an explanation. | | |
| | | | |
| | | | |
| 16. | I hereby certify that the patient has been and or will be totally disabled from carrying out his / her usual occupational duties as follows: | | |
| | From: | To: (inclusive) | |
| 17. | Additional remarks: (e.g. Prognoses, life expectancy, occupational rehabilitation, surgery waiting list) | | |
| | | | |
| | | | |
| | | | |

| | | |
|---|---|---|
| Doctor's Name: | | |
| Doctor's Address: | | |
| Telephone No: | Facsimile No: | |
| I hereby certify that I have personally examined the above-named claimant and that in my opinion the statements made in the Statement of Claim section of this Claim Form are consistent with the Claimant's Injury or Sickness. | | |
| I have read and accept the Privacy Collection Statement provided with this Claim Form. | | |
| **Signature:** | **Qualifications:** | **Dated:** |

# ECHELON AUSTRALIA PTY LTD

**ABN 96 085 720 056**

## COLLECTION STATEMENT UNDER PRIVACY ACT 1988 (Cth)

In accordance with the Privacy Act 1988 (Cth) (and subsequent amendments), we Echelon Australia Pty Ltd (Echelon), including Echelon Claims Services, draw your attention to the following:

- We may collect personal information about you.
- We are collecting the information principally for the purpose of approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other Echelon products or services. If you are proposing for or renewing insurance or membership, or membership of a Jardine Lloyd Thompson Discretionary Trust Arrangement (JDT Arrangement), the information is required pursuant to your Duty of Disclosure under the Insurance Contracts Act 1984 (Cth), the Marine Insurance Act 1909 (Cth) or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and Echelon related Group companies, such as Jardine Lloyd Thompson Pty Ltd (JLT). Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- By providing this information, you agree to us collecting, using and disclosing your personal information as outlined in this Collection Statement.
- If you do not provide all or part of the information requested, we may be unable to process your application or provide other required services, your application for insurance or membership of a JDT Arrangement may be declined or you may prejudice your insurance cover or cover under a JDT Arrangement.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988 (Cth).
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988 (Cth), you must obtain it with the individual's consent.
- Our Privacy Policy can be made available on request or can be accessed on JLT's website www.au.jlt.com.
- For further information regarding **Echelon's Privacy Policy**, contact your Account Executive, Claims Manager or the Privacy Officer for JLT and Echelon.

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