Community
Underwriting

# Community Underwriting
# Personal Accident Claim Form

## About Community Underwriting

Community Underwriting Agency Pty Ltd (Community Underwriting) acts under a binding authority as Agent for Berkley Insurance Australia to issue, vary and cancel policies on Berkley's behalf. In all aspects of this Policy, Community Underwriting acts as an agent for Berkley Insurance Australia, the Insurer and not for the Insured.

## About the Insurer

Berkley Insurance Australia (Berkley - ABN 53 126 559 706) is part of the Berkley Group of Companies. Founded in 1967 the Berkley Group of Companies is one of the USA's premier commercial lines property and casualty insurance providers. Each of the operating units in the Berkley group participates in a niche market requiring specialised knowledge about a territory or product.

The Berkley Group of companies is led by Berkley Corporation, located in Greenwich, Connecticut, USA. It is listed on the New York Stock Exchange under the symbol WRB. Member companies of the Berkley Group have offices across the USA and in the United Kingdom, South America, Continental Europe, Australia, Singapore and Hong Kong.

## Privacy Statement

Community Underwriting and Berkley Insurance Australia seek at all times to comply with the Privacy Act 1988 and the Australian Privacy Principles therein. If We disclose personal information to You for any reason You must also act in accordance with and comply with the terms of the Privacy Act and the Australian Privacy Principles.

Purpose for collection of information:

The information contained in this document and any other documents provided to Us will be dealt with in accordance with our respective Privacy Policies.

Disclosure of Information that you provide to us:

Community Underwriting and Berkley Insurance Australia will only use the information in accordance with the terms of the Privacy Policies. Without limiting the application of the Policy Comunity Underwriting and Berkley Insurance Australia may disclose personal information to other individuals or organisations in connection with Your claim, including legal advisors, other parties, other lawyers, experts and witnesses, courts and tribunals and other organisations that need to be involved in the matter. By submitting Your notification and continuing to deal with us you consent to Community Underwriting and Berkley Insurance Australia and these parties collecting, using and disclosing personal and sensitive information about you for these purposes. By signing the claim form You are consenting to the above.

You warrant to us that where you provide us with personal information that you have collected from other individuals:

- that the information has been collected in accordance with the Privacy Act 1988.
- that We are authorised to receive that information from you and to use it for the purpose of providing legal claims management services and advice.
- You, and the person who provided You with the information, are aware and have complied with the Privacy Act 1988 and have notified the person about whom the personal information is collected of the collection use and disclosure of such information.

By executing the claim form you are indemnifying Community Underwriting and Berkley Insurance Australia against any breach that arises directly or indirectly out of any act or omission of your part which does not accord with the conduct required under the Privacy Act 1988.

Direct Marketing:

We do not disclose personal information that We collect to a third party for the purpose of allowing them to direct market their products and services unless You have given Us Your permission for Us to do this.
Cross Border:

We will share Your personal information with the Community Underwriting and the Berkley group of companies. Our data containing Your information is stored in our data centre using dedicated hardware and network. We may also use Saas, Cloud computing or other technologies from time to time and Your information may be stored outside Australia. We will not transfer personal information to a recipient in a foreign country unless We have appropriate protections in place as required by the relevant privacy laws. Your information will be stored on our data base for such period of time as required by law.

Further information

If you would like further information, please review our full Privacy Policy on our website or if you have any complaints or concerns over the protection of the information you have given to us or that we have collected from others, contact the National Head of Claims at the Sydney address listed below or alternatively send an email to australiaclaims@berkleyinaus.com.au.

Berkley Insurance Australia
Level 23, 31 Market Street
Sydney NSW 2000
Ph: 02 9275 8500
Fax: 02 9261 2773
Email: australia@berkleyinaus.com.au
Web site: www.berkleyinaus.com.au

## GST and Insurance Requirements

If you are registered for GST purposes and have an entitlement to claim an Input Tax Credit (ITC) for GST paid on your insurance, you are required to inform your insurer, at or before the time of any subsequent claim, of the extent to which you are eligible to claim an ITC.

The amount that we are liable to pay under this policy will be reduced by the amount of any ITC that you are or may be entitled to claim for the supply of goods or services covered by that payment.

If you are liable to pay an excess under this policy, the amount payable will be calculated after deduction of any ITC that you are or may be entitled to claim on payment of the excess.

## Complaints

Any enquiry or complaint relating to this insurance should in the first instance be referred to:

Complaints Manager

Community Underwriting Agency Pty Ltd

P.O. Box 173, Balmain NSW 2041

If this does not resolve the matter or You are not satisfied with the way a complaint has been dealt with, you should contact:

The National Head of Claims

Berkley Insurance Australia

P.O Box Q296, QVB Sydney NSW 1230

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## Section 1 Volunteers Information

Name: _____

Address: _____ Postcode: _____

Telephone: (Work): _____ (Home): _____

Mobile: _____

Date of Birth: / / Height: _____ Weight: _____ Sex: M ☐ F ☐

Normal occupation prior to disablement: _____

Association or Organisation you volunteer for: _____

**Details of injury**

A. Give full description of injury from which you are suffering. State when, where and how it happened. (attach extra page if required).

Type of injury:

_____

_____

_____

_____

How did injury occur?

_____

_____

_____

_____

Place where you were injured: _____

Date of injury: / / Time: am/pm Training: Yes ☐ No ☐ Playing: Yes ☐ No ☐

B. 1) Have you ever had this, or a similar condition in the past? Yes ☐ No ☐

2) If yes, state nature of the condition, dates of treatment and names and addresses of treating doctors, hospitals or clinics (attach extra page if insufficient space).

Condition(s):

_____

_____

_____

_____

Date: / / Treated by: _____

**To be completed by the Association/ Organisation.** Please ensure that all questions have been fully answered.

Name of Volunteer: _____ was injured as stated.

Name of Association/ Organisation: _____

Name of person completing this form: _____ Telephone: _____

Position of person completing this form: _____

Address of Association: _____

_____ Postcode: _____

**I HEREBY CERTIFY THAT the particulars shown on this form are, to the best of my knowledge, true and correct.**

Signature: _____ Date: / /

Witness: _____ Date: / /

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## Section 2 Details of Non Medicare Expenses Claimed

NB. Only forward accounts for services which are not subject to a Medicare rebate ie. Physiotherapy, Chiropractic, Ambulance Private Hospitals, Dental etc.

Are you a member of a private health fund? Yes ☐ No ☐

If yes, which one? _____

Hospital cover: Yes ☐ No ☐ Extras covering dental, physiotherapy, etc. Yes ☐ No ☐

| Date of treatment | Name of provider | Type of service | Amount | Health fund rebate | Amount claimed |
|---|---|---|---|---|---|
| a) / / | | | | | $ |
| b) / / | | | | | $ |
| c) / / | | | | | $ |
| d) / / | | | | | $ |

When did you first consult a physician for this condition? / /

When did you become totally disabled (unable to work)? / /

When were you able to again perform part of your occupational duties? / /

If still totally disabled, when do you expect your disability to terminate? / /

When will you resume training? / /

Hospital: _____ From: / / To: / /

Address: _____

a) Give names, address and telephone numbers of all attending physicians. (Attach extra page if insufficient space)

| Name | Address | Telephone |
|---|---|---|
| | | |
| | | |

b) Give names, address and telephone numbers of usual family physicians. (Attach extra page if insufficient space)

| Name | Address | Telephone |
|---|---|---|
| | | |
| | | |

## Section 3 Loss of Income Claims

**1. If self employed** (please attach proof of earnings over past 12 months eg. Tax Return)

Who is your accountant? _____

Address: _____

Telephone: _____

**2. If employed as a wage earner** (to be completed by your employer)

**I HEREBY CERTIFY THAT:** _____

has been unable to attend his/her usual occupation with the Company as a result of an injury/injuries suffered on / /

He/she has been incapacitated since / / and is expected to/did resume duties on / /

His/her gross basic salary (excluding bonuses, commission and overtime) at the date of the injury was $ per week.

During this period of incapacity he/she received:

a) Normal pay: $ _____ From: / / To: / /

b) Sick pay: $ _____ From: / / To: / /

c) Workers compensation: $ _____ From: / / To: / /

d) Other (please specify): $ _____ From: / / To: / /

He/she has been employed since: _____

His/her sick leave entitlements at date of injury is _____ days.

Name of company: _____ Company stamp:

Address: _____

Name of Manager or Paymaster (please print): _____

Signature of Manager or Paymaster: _____

Telephone: _____ Date: / /

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| Section 3 | Loss of Income Claims continued |
|---|---|

Are you claiming or entitled to claim any other form of income (eg. Department of Social Services, loss of income protection insurance, etc.)? If so, please provide details:

## Declaration and Authorisation

I hereby authorise any hospital, physician or any other person who has attended me, or any employer, to furnish **Community Underwriting, Berkley and their agents** with any and all information with respect to any sickness or injury, medical history, consultations, prescriptions, or treatment, copies of all medical records and copies of all records of employers including verification of earnings.

I declare that I have read and understood the Privacy information and consent to the collection, storage, use and disclosure of personal and sensitive information of all persons covered by this Form. Where personal information has been provided on someone else's behalf, that person has consented to this provision.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail.

**Signature of Volunteer:** _____ **Date:** ____/____/____
(or parent /guardian if under 18 years of age)

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## Section 4 Attending Physicians Statement

(The insured is responsible for completion of this form without expense to the Company)

Patients name: _____ Sex: M ☐ F ☐

Address: _____

What is disabling patient? (please give a complete diagnosis of this condition)

_____

_____

_____

**History**

1. When did patient first receive medical treatment? ___/___/___
2. Was there a previous history of this or a similar condition? Yes ☐ No ☐

If yes, please state condition and advise when previous treatment given.

_____

_____

_____

_____

_____

3. a) How long have you known the patient? _____

   b) Are you the regular general practitioner? Yes ☐ No ☐ If

   no, please advise who is: _____

**If Injury**

1. When did patient suffer the injury? ___/___/___
2. What were the circumstances surrounding the injury?

_____

_____

_____

_____

_____

**If Disability**

1. Patients occupation? _____
2. When was patient obliged to cease work? ___/___/___
3. Is patient still disabled, when will the patient be able to commence any type of employment?

   a) Some duties: _____ b) Full duties: _____

4. If patient has recovered, when was patient able to resume?

   a) Some duties: _____ b) Full duties: _____

**Treatment of present condition**

1. When were you initially consulted?

   a) Initially? ___/___/___ b) Most recently? ___/___/___

2. How often has the patient consulted you? _____
3. Was the patient confined to hospital? Yes ☐ No ☐

   If yes, please advise. Hospital name: _____

   Address: _____

   Period of confinement: From ___/___/___ To ___/___/___

4. Was confinement in a convalescent home necessary after hospitalisation? Yes ☐ No ☐

   If yes, please give details:

_____

_____

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**Treatment of present condition (cont'd)**

5. What are the current subjective symptoms?

6. Please give results of any objective finding:
   a) X-rays

   b) Other test - Please advise test done and findings:

7. What surgical procedures have been performed?

8. What surgical procedures have been contemplated?

9. What other treatment has the patient undergone?

10. What other treatment is required?

11. Are there any underlying conditions affecting recovery from the current condition? Yes ☐ No ☐
    If yes, please advise nature of underlying conditions and how they affect disability and recovery?

12. Has the patient any other physical or mental impairment? Yes ☐ No ☐
    If yes, please describe:

13. Please advise names and addresses of other treating physicians.

| Name | Address | Telephone |
|---|---|---|
| | | |
| | | |
| | | |

14. If you have terminated treatment please advise date: / /

15. What is your current prognosis?

16. Is there any further remarks which may assist in assessing this condition?

17. Is there any permanent disability present? Yes ☐ No ☐
    If yes, please explain giving estimated percentage of loss function.

Name: _____ Telephone _____

Address: _____ Postcode _____

Signature: _____ Date: / /

Degree: _____