



Community Underwriting

Voluntary Workers Personal Accident Claim Form

About Community Underwriting

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

About the Insurer

Mitsui Sumitomo Insurance Company Ltd (MSI) ABN 49 000 525 637 AFS License No. 240816 is part of the Tokyo listed MS & AD Insurance Group with a global network of offices across 42 countries and regions.

Privacy

We 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:

We will only use the information in accordance with the terms of the Privacy Policies. Without limiting the application of the Policy We 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 Us 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 Us 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 MS & AD Insurance 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.

Community Underwriting Agency Pty Ltd - AFS License No 448274 (Community Underwriting) acts under a binding authority as Agent for Mitsui Sumitomo Insurance Company Ltd (MSI) ABN 49 000 525 637 AFS License No. 2401816 to issue, vary and cancel policies on Mitsui's behalf. In all aspects of this Policy, Community Underwriting acts as an agent for the insurer and not for the insured.

Further information

If you would like further information, please review the full Privacy Policy at www.communityunderwriting.com.au and www.msi-oceania.com 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:

Community Underwriting Agency Pty Ltd
P.O. Box 173, Balmain NSW 2041
Telephone 02 8045 2580

Mitsui Sumitomo Insurance Company Limited
Level 26, 135 King Street
Sydney, NSW 2000
Telephone 02 9222 7600

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:

Mitsui Sumitomo Insurance Company Limited
Level 26, 135 King Street
Sydney, NSW 2000
Telephone 02 9222 7600
Facsimile 02 9232 7006

Community Underwriting are specialists in charity insurance, not for profit insurance and insurance for community organisations. We offer a range of insurance solutions customised to meet the needs of community organisations.
Contact us today!

Call us: 02 80452580
enquiries@communityunderwriting.com.au
www.communityunderwriting.com.au

AFS No 448274 ABN: 60 166 234 715

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: ____ / ____ / ____

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: / /

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, Mitsui Sumitomo 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)

PLEASE HAVE YOUR ATTENDING MEDICAL PROFESSIONAL COMPLETE THE STATEMENT ON THE NEXT PAGE

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:

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: _____