

CLAIM FORM ➔

Injury and Sickness

EXT076

For dental claims, please use the **Protect Accidental Dental Injury claim form**.

Call ATC for assistance on **1800 994 694**

1a. You complete Section A, including either the Injury Statement OR the Sickness Statement.

1b. If you are claiming for income protection you also complete the attached Tax File Number Declaration form. In the event of your claim being accepted, any income protection benefits paid to you will have income tax deducted in the same way your employer deducts it from your salary. You are not obligated to submit the Tax File Declaration form, however failure to do so will result in your income protection benefits being taxed at the maximum applicable rate set by the Australian Taxation Office.

2. Your **Medical Practitioner** completes Section B.

3. Your **employer** completes Section C and includes a 12 month pay report substantiating your average weekly earnings.

4. If you went to hospital following an injury, attach a copy of the hospital admission notes. If you have a broken bone, attach a copy of the radiological report.

5. Check all questions have been answered (including by selecting either Yes or No wherever this option is given) and each section has been signed and dated.

Your claim will be delayed if we have to return your claim form to you because it is incomplete.

6. Please keep a copy of the completed claim form and attachments for your records.

7. Send, or fax, or scan and email, or deliver your completed form in person to:

Post: ATC Insurance Solutions Pty Ltd
Level 4, 451 Little Bourke Street, Melbourne Vic 3000
Fax: (03) 9867 5540
Email: info@atcis.com.au

Important Information

1. Assistance with Completing the Claim Form

- Call our dedicated Protect claims team on 1800 994 694 during business hours.
- Union Members can also contact their union directly for assistance.
- For assistance with completing the Tax File Number Declaration form please contact your financial advisor, accountant or the Australian Tax Office on 13 28 61.

2. Work Related Injuries and Sicknesses

- Protect Injury and Illness insurance is designed primarily to support members who have a non-work related injury or illness.
- There are only a few work related situations covered by Protect insurance, such as death, total and permanent disablement or workplace accident top-up benefits which may be payable after receiving workers' compensation benefits for 52 weeks. (Top-up benefits for the first 52 weeks of a workplace injury or illness claim may be covered by your enterprise agreement and, if so, are payable directly by your employer; check with your employer, your union or Protect.)
- For more information contact our dedicated claims team on 1800 994 694.

3. Claim Assessment

- Every claim is unique and the assessment time will depend on the complexity of your medical condition and how quickly we can obtain all the information required to process the claim.
- You can help prevent any unnecessary delays by ensuring all relevant questions in the claim form are answered and any additional documentation is provided as quickly as possible.

4. Waiting Periods

- All Protect insurance claims have a waiting period, during which no benefits are payable.
- For workers' compensation top-up claims, there is a 52 week waiting period. (Top-up benefits for the first 52 weeks of a workplace injury or illness claim may be covered by your enterprise agreement and, if so, are payable directly by your employer; check with your employer, your union or Protect.)
- For all other claim types, there is typically a waiting period of either 14 or 30 consecutive days however please check your enterprise agreement or contact Protect or ATC to confirm your applicable waiting period.

5. Medical Certificates

- Valid medical certificates are required for any period of incapacity, including weekends.
- A valid medical certificate must include:
 - Your medical practitioner's name and signature
 - Your name
 - The full cause of your incapacity (eg John Smith is suffering from a broken left ankle)
 - The start and end dates of your incapacity.

6. Additional Documentation Required

- Amateur Sports Claims (eg during a game with your local football club)
 - If your sports club has income protection cover for players, lodge a claim first with the sports insurer and provide the claim details to ATC by completing this Protect claim form. You may also be able to claim for medical expenses with your sports insurer.
 - If your sports club does not have this cover, we require written confirmation on club letter head, signed by a senior club official.
- Conditions Requiring Hospitalisation
 - If you were, or will be, admitted to hospital, please provide copies of any documentation you are provided with, such as admission notes, test results and discharge information.
- Non Work-Related Injuries Involving a Bone Fracture
 - Some non work-related injury claims (but not all) may qualify for a lump sum 'broken bone' benefit, payable once you receive medical clearance to return to work.
 - If you have sustained a fracture, please provide a copy of your radiological report with your claim.
- Workers' Compensation Top-Up Claims
 - Please provide your workers' compensation claim details and a copy of your acceptance letter.
 - During an accepted top-up claim, we will require copies of either:
 - workers' compensation remittance slips showing your payments or
 - Pay slips from your employer, if your workers' compensation payments are paid via your employer.
- Transport Accident Top-Up Claims
 - Please provide us with the relevant details of your accepted transport accident claim including a copy of the letter outlining the decision regarding income replacement benefits.
 - Throughout the duration of an accepted transport accident top-up claim, we will require copies of remittance slips showing the payments made to you by the relevant statutory body.

A full copy of Protect claim form 'Frequently Asked Questions' is available from our website at www.atcis.com.au/FrequentlyAskedQuestions

SECTION A Claimant's Statement

Claimant's Details

Protect number (if known) _____

Union member Yes No Union name _____ Membership no. _____

Title _____ First name/s _____ Last name _____

Sex Male Female Date of birth ____/____/____ Height _____ cm Weight _____ kg

Home Telephone _____ Mobile _____

Email _____

Street Address _____

Suburb _____ State _____ Postcode _____

Postal Address (if different from above) _____

Suburb _____ State _____ Postcode _____

What is your preferred method of communication (telephone, postal or email)? _____

Employment Details

Name of employer _____

Employed since ____/____/____ Occupation/Job title _____

Employment status Full time Part time Casual Contractor

On average how many days do you work per week? _____ Hours worked per day _____

Please list your usual duties and percentage of time spent on each task (eg cable installation – 80%).

DUTIES	% TIME SPENT
_____	_____
_____	_____
_____	_____

Bank Details

If your claim is approved, your claim benefits will be transferred directly to your bank account. Please provide your account details.

Bank name _____ Bank branch _____

Account name _____

BSB _____ Account no. _____

- 1a.** Date of injury ____/____/____ **1b.** Time of injury _____ am ____ pm ____
- 2.** On what date did you first seek medical treatment or advice? ____/____/____
- 3.** First date off work because of the injury ____/____/____
- 4.** Describe your injury and the parts of your body that were affected (eg fractured right ankle) _____

- 5.** In your own words, describe the incident that caused your injury and what you were doing before it happened _____

- 6.** Provide the location, including street address, of where the incident occurred _____

- 7.** Were there any witnesses to the incident? Yes No
- 7a.** If Yes, provide witness name/s and contact number/s _____

- 8.** Was an ambulance called? Yes No
- 9.** Did the incident occur at work, including during a meal-break or authorised recess at work? Yes No
- 10.** Provide details of your General Practitioner (GP) and all other medical practitioners seen for your current injury. Please show the date you first saw each practitioner, even if for a condition other than your current injury.

PRACTITIONER'S NAME	PERIOD OF ATTENDANCE		SPECIALTY	PHONE	FAX
	FROM	TO			

- 11.** Have you ever had a similar injury before? Yes No
- 11a.** If Yes, please describe the injury, when and how it happened and whether there is any connection between the previous injury and the current injury _____

11b. List medical consultations for the similar injury

PRACTITIONER'S NAME	PERIOD OF ATTENDANCE		SPECIALTY	PHONE	FAX
	FROM	TO			

- 12.** Have you returned to work? Yes No **12a.** Date returned ____/____/____
- 13.** When do you anticipate you may be fit enough to return to full-time work? ____/____/____
- 14.** Please give as much detail as possible about the type of treatment you are receiving _____

1. In your own words, describe the sickness that is disabling you _____

2. On what date did you first notice the symptoms of your sickness? ____/____/____
3. On what date did you first seek medical treatment or advice? ____/____/____
4. First date off work because of the sickness ____/____/____
5. Do you believe your work has caused your condition, or was a significant contributing factor in its development? Yes No
6. Provide details of your General Practitioner (GP) and all other medical practitioners seen for your sickness.
Please show the date you first saw each practitioner, even if for a condition other than your current sickness.

PRACTITIONER'S NAME	PERIOD OF ATTENDANCE		SPECIALTY	PHONE	FAX
	FROM	TO			

7. Have you ever had a similar condition in the past? Yes No

7a. If Yes, list medical consultations for the similar condition.

PRACTITIONER'S NAME	PERIOD OF ATTENDANCE		SPECIALTY	PHONE	FAX
	FROM	TO			

- 7b. Is there a relationship between the previous condition (if there was one) and your current sickness? Yes No

7c. If No, explain why not _____

- 7d. Have your medical practitioners ever advised you that you could cease all treatment or advice for this previous condition?

Yes No

8. Have you returned to work? Yes No 8a. Date returned ____/____/____

9. When do you anticipate you may be fit enough to return to full-time work? ____/____/____

10. Please give as much detail as possible about the type of treatment you are receiving _____

1. For this injury or sickness can you claim against any of the following? (select either Yes or No)

- | | | |
|---|---------------------------|--------------------------|
| 1a. Workers' compensation insurance | Yes <input type="radio"/> | No <input type="radio"/> |
| 1b. Motor accident compensation insurance | Yes <input type="radio"/> | No <input type="radio"/> |
| 1c. Centrelink and/or Government disability benefits | Yes <input type="radio"/> | No <input type="radio"/> |
| 1d. Sports club or recreation centre's income protection policy | Yes <input type="radio"/> | No <input type="radio"/> |
| 1e. Superannuation fund (income protection insurance) | Yes <input type="radio"/> | No <input type="radio"/> |
| 1f. Any other insurance policy (eg travel) | Yes <input type="radio"/> | No <input type="radio"/> |

1g. If Yes to any of the above, please provide further details (including the insurer's name and your claim number) _____

Optional Authority

The following authority is optional and should only be completed if you wish or require another person to act on your behalf in relation to this claim. Generally, such an authority should only be provided when the claimant is incapacitated, not an adult, or other difficulties prevent you from acting effectively on your own behalf with regard to this claim.

Complete if applicable. I hereby authorise the person named below to act on my behalf in relation to this claim and authorise ATC to discuss and share any relevant information.

Name of person acting on your behalf _____

Relationship to claimant _____

Telephone _____ Email _____

Street address _____

Suburb _____ State _____ Postcode _____

Signature (of claimant, if appropriate) _____

Privacy

In this statement "we", "us" and "our" means Lloyd's and ATC Insurance Solutions (ATC) as its agent.

We are bound by the requirements of the *Privacy Act 1988* (Cth), the *Privacy Amendment (Private Sector) Act 2000* (Cth) and the *Privacy Amendment (Enhancing Privacy Protection) Act 2012*. This sets out standards on the collection, use, disclosure and handling of personal information.

Our Privacy Policy is available at www.atcis.com.au or by calling us on the number below.

We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties (and/or collect additional personal information about you from them) who assist us in providing the above services and some of these are likely to be overseas recipients in the United Kingdom. These parties which include our related entities, distributors, agents,

insurers, claims investigators, assessors, lawyers, medical practitioners and health workers, and federal or state regulatory authorities, including Medicare Australia and Centrelink will only use the personal information for the purposes we provided it to them for (unless otherwise required by law).

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- you have the authority from them to do so and it is as if they provided it to us;
- you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information and request correction if required. You may also opt out of receiving materials sent by us by contacting ATC on (03) 9258 1700 or write to us at the address given on page one.

Authority and Declaration

I hereby authorise any hospital, physician, insurer, Medicare Australia, my employer or other person who has attended me to furnish to ATC or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding workers' compensation claims, claims with any other insurer, or any leave benefits and payments, to be released to ATC. I agree that a photocopy or facsimile of this authorisation shall be considered as effective and valid as the original.

I declare that:

- a. the claim I am making for injury or sickness IS NOT WORK-RELATED and if my injury or sickness is work-related, I have disclosed this clearly in my answers in this section, and**
- b. my answers are true and correct and I agree that if I have made, or in any further declaration in respect of the claim make, any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever, my cover shall be void and I will lose my rights for this claim and any future claims.**

Name (print) _____

Signature _____ Date ____/____/____

Important notice: If you have declared this claim is not work-related and a claim is made under this policy that is rightfully a workers' compensation claim, it is possible a fraudulent act has been committed that may result in prosecution. You must tell us if you return to work or become medically fit to do so. If you fail to tell us and continue to receive benefits under the policy you could be prosecuted for fraud. You might also lose all of your rights under the policy for this claim and any future claims.

SECTION B Medical Practitioner's Statement

All questions in Section B to be completed in full by the medical practitioner. Please provide as much detail as possible.
Important: The claimant is responsible for any fee for this statement.

Claimant's full name _____

Sex Male Female Date of birth ____/____/____ Height _____ cm Weight _____ kg

1a. Date of injury (if applicable) ____/____/____ 1b. Time of injury _____ am ____ pm ____

2. Date of onset of first symptoms of the claimant's condition ____/____/____

3. Date you were first consulted for this condition ____/____/____

4. Date of actual diagnosis of the claimant's condition ____/____/____

5. What is your current diagnosis of the claimant's condition? _____

6. Are the symptoms referred to in question 2 consistent with your current diagnosis? Yes No

7. What was the proximate cause of the condition (eg describe the incident that resulted in an injury)? _____

8. Do you believe that the claimant's work has caused their condition, or was a significant contributing factor in its development?

Yes No

8a. Please provide an explanation for your answer _____

9. Is the cause of this condition related to any sort of motor vehicle (including motorcycle) accident or incident? Yes No

10. What is currently disabling the claimant and causing absence from work _____

11. Is any other injury or sickness contributing to the disablement? Yes No 11a. If Yes, give details _____

12. What tests to determine a diagnosis have been undertaken and what further tests are anticipated? _____

13. Has treatment or advice been sought from other medical practitioners? Yes No

13a. If Yes, advise details of the consultations _____

Medical Practitioner's Statement SECTION B continued

14. Has the claimant ever previously suffered from the same or a related condition? Yes No

14a. If Yes, advise details of the previous condition and who treated the claimant _____

14b. If a re-occurrence of the *same* condition was this to be expected? Yes No

14c. If an occurrence of a *related* condition was this to be expected? Yes No

14d. Has the claimant previously been hospitalised for this condition? Yes No 14e. If Yes, advise details _____

15. Do you consider that the claimant has been/will be wholly and continuously prevented from carrying out his or her usual duties?

Yes No

15a. If Yes, please advise a *minimum* period for which the claimant has been/will be disabled.
We appreciate that disablement may extend beyond the current date provided.

Minimum period of disablement From ____/____/____ To ____/____/____

16. Is there anything in the claimant's history that may delay recovery? Yes No

16a. If Yes, please provide details and how long recovery may be delayed _____

17. What is the claimant's treatment/rehabilitation program? _____

18. What is the claimant's prognosis? _____

19. When will the claimant be fit for full duties? ____/____/____

19a. When will the claimant be fit for alternative duties? ____/____/____

19b. If the claimant is fit for alternative duties, what type of duties do you consider suitable? _____

20. If the claimant has a broken bone, advise the type and extent of the break, including whether it is a hairline fracture only

21. How long has the claimant been attending your practice? _____

I hereby certify that I have personally examined the above-named claimant.

Name _____ Qualification _____

Telephone _____ Fax _____ Email _____

Street address _____

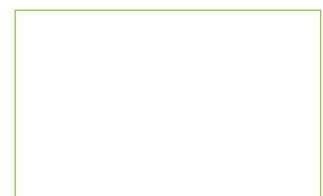
Suburb _____

State _____ Postcode _____

Signature _____

Date ____/____/____

AFFIX STAMP HERE



SECTION C ➔ Employer's Statement

All questions in Section C to be completed in full by the employer.

Company name _____

Project name (if applicable) _____

Telephone _____ Fax _____ Email _____

Street Address _____

Suburb _____ State _____ Postcode _____

1. I hereby certify that (insert claimant's name) _____

has been or will be totally/partially absent from work effective ____/____/____

and is due to return did return to work on ____/____/____

2. The *average* weekly income including all overtime and allowances (before personal deductions and income tax) actually paid to the claimant during the 12 month period immediately preceding disablement was \$ _____

We require a 12 month pay report substantiating the claimant's average weekly earnings in order to process this claim.

If the claimant has been employed for less than 12 months, please provide a pay report for the applicable period of employment.

3. If a Workers' Compensation or similar claim are applicable, please provide details (including name of the insurance company, claim/policy number and contact details) _____

4. Date the claimant commenced with the company ____/____/____

4a. Claimant's current work status Full time Part time Casual Contractor

Employment terminated ____/____/____ Employment to be terminated ____/____/____

4b. If the claimant's employment has been/will be terminated, please advise reasons _____

5. Are you prepared to offer the claimant suitable alternative duties? Yes No

5a. If Yes, please provide details of those duties _____

6. To the best of my knowledge, the claimant's injury or sickness is work-related? Yes No

6a. Is the claimant entitled to lodge a Workers' Compensation claim for this injury or sickness? Yes No

Declaration

Unless otherwise indicated above, I declare that the claimant's injury IS NOT WORK-RELATED, and the answers given are true and complete.

Name _____

Signature _____ Date ____/____/____

Important notice: If you have declared this claim is not work-related and a claim is made under this policy that is rightfully a workers' compensation claim, it is possible a fraudulent act has been committed that may result in prosecution. Furthermore, by making a claim under this policy, the Claimant may forgo any long-term benefits and rights under workers' compensation.