CEPU/ETU Accidental Capital Benefit Claim Form

ACCIDENTAL CAPITAL BENEFIT CLAIM

In order to alleviate any delay in the processing time of your claim, please ensure the following:

- The claim form is returned with all fields completed. Incomplete forms will be returned to obtain missing information.
- Medical certificates need to be original and must state the condition for which you are claiming.
- In relation to Workers Compensation/Compulsary Third Party claims, please provide an Acceptance/Decline letter and if liability has been accepted please provide copies of all benefits.
- If you are in receipt of Centrelink or any other benefits as a result of your condition, please provide copies of all benefits paid.
- Please enclose copies of Medical reports including x-ray's

CEPU/ETU Accidental Capital Benefit Claim Form

Instructions:

1. **Section A** is to be completed by you, the claimant.
2. **Section B** is to be completed by your treating doctor.
3. Please enclose:
   a. Original Medical Certificates
   b. Reports including X-rays
4. Mail completed form to: **Australian Income Protection Pty Ltd**
   PO Box R1196, Royal Exchange, NSW 1225.
5. If have any enquiries please call **Australian Income Protection™ Pty Ltd** on (02) 8252 7900 or 1300 559 362 (only from landline)

IMPORTANT NOTICE
Any fraud, misstatement or concealment by you in relation to any matter affecting this insurance in connection with making of any claim under it, will give us the rights provided for in the Insurance Contract Act, including where appropriate the right to reduce or refuse payment of any claim.

Section A - Claimant's Section - To be completed by claimant

All questions must be completed and claim form signed before claim will be processed. **(Please print)**

Title:		First name(s):			
Last name:					
Address:					
Suburb		State:		Postcode:	
Phone:	( )	Mobile:			
Fax:	( )				
Email:					
Date of birth:	/ /	Gender:	Male □	Female □	

Employment details:

Employer:

Address:

Suburb: State: Postcode:

Work ph: ( ) Work fax: ( )

Email:

Length of employment: Years: Months:

Occupation:

Usual duties:

Medical Information:

Date of injury: / / Time occured: **am/pm**

Name and extent of injury:

Please state what you were doing and how it happened:

Have you suffered from this injury before?: Yes □ No □

Date previous injury occured: / /

If Yes, please provide details:

Was surgery required?: Yes □ No □

If Yes, when was the surgery?: / /

Date you first sought medical attention for current condition: / /

Police Details (If applicable):

Reporting Police Officers Name:

Police Station:

Police Report Number:

Name and address of your medical Practitioner(s) for the past 5 years:

You must fully complete your medical practitioner's information below or your claim may be delayed up to 10 weeks while we obtain a full Medicare history report.

Name:

Address:

Suburb: State: Postcode:

Ph: ( ) Fax: ( )

Date first attended: / / Date last consulted: / /

Years attended:

Name:

Address:

Suburb: State: Postcode:

Ph: ( ) Fax: ( )

Date first attended: / / Date last consulted: / /

Years attended:

(If you have visited more than 2 medical practitioners over the last 5 years provide the information attached to this claim form.)

Additional Benefits Checklist: (please tick either Yes or No to each question)

If you answer Yes to any of the below, please provide proof of claim / benefit. For example: provide acceptance letter, decline letter and copies of benefits paid.

Have you or will you lodge a motor accident claim?: Yes ☐ No ☐

Was your injury work related?: Yes ☐ No ☐

If Yes, have you or are you going to lodge a claim for Workers Compensation?: Yes ☐ No ☐

Insurance Co for Workers Comp:

Are you receiving any additional benefits from your employer ?:

Sick leave: Yes ☐ No ☐

Annual/holiday leave: Yes ☐ No ☐

Long service leave: Yes ☐ No ☐

Other: Yes ☐ No ☐

Have you or will you lodge a claim with Centrelink?: Yes ☐ No ☐

Have you or will you lodge a claim for any sports insurance benefit?: Yes ☐ No ☐

Have you or will you lodge any other type of insurance claim?: Yes ☐ No ☐

If Yes, please provide details below:

Insurance company:

Policy number:

Contact details:

Type of policy:

Benefit Table: (Please tick the event in which you wish to claim, from the benefit table below)

The events	
Total Permanent Disablement	☐
Permanent Paraplégie	☐
Permanent Quadriplégie	☐
Permanent Total Loss of Sight of both eyes	☐
Permanent Total Loss of sight of one eye	☐
Permanent Total Loss of use of two limbs.	☐
Permanent Total Loss of use of one limb.	☐
Permanent and Incurable Insanity	☐
Permanent Total Loss of hearing in both ears	☐
Permanent Total Loss of Hearing in one ear	☐
Permanent Total Loss of four fingers and a thumb (either hand)	☐
Permanent Total Loss of the lens of both eyes	☐
Permanent Total Loss of the lens of one eye	☐
Third Degree burns and/or resultant disfigurement which covers more than 40% of the entire external body	☐
Permanent Total Loss of use of four fingers of either hand	☐
Permanent Total Loss of use of one thumb both joints (either hand)	☐
Permanent Total Loss of use of one thumb one joint (either hand)	☐
Permanent Total Loss of fingers of either hand three joints	☐
Permanent Total Loss of fingers of either hand two joints	☐
Permanent Total Loss of fingers of either hand one joint	☐
Permanent Total Loss of use of toes of either foot - all, one foot	☐
Permanent Total Loss of use of toes of either foot - great, both joints	☐
Permanent Total Loss of use of toes of either foot - great, one joint	☐
Permanent Total Loss of use of toes of either foot - other than great, each toe	☐
Fractured leg or patella, with established non union	☐
Permanent Shortening of leg by at least 5 cm	☐

Australian Income Protection

Authority

I hereby authorise any hospital, physician, employer insurer, Health Insurance Commission, Union or other person who has attended me to furnish to Australian Income Protection Pty Limited or its representatives any and all information with respect to the injury, medical history, consultation, prescription or treatment and copies of all medical records. I also authorise any and all information regarding Worker's Compensation claims or claims with any other insurer to be released to Australian Income Protection. I agree that a Photostat or fax copy of this authorisation shall be considered as effective and valid as the original. I also authorise Australian Income Protection to release any information requested by CEPU QLD and/or ETU or its representatives in relation to the claim.

Declaration

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made or in any further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recovery there under or in respect of past or future claims shall be forfeited.

Signature of Claimant:	
Name of Claimant:	
Date:	/ /

Claim form check list:

- Have all sections been completed?
- Have you supplied a list of all treating doctors over the last 5 years?
- Have you supplied medical reports including x-rays?

Your claim will be delayed unless all sections are complete. Send the completed form to:

Australian Income Protection Pty Ltd
Attn: Claims department
PO Box R1196, Royal Exchange, NSW 1225

Section B - Doctor's Section - To be completed by the Doctor

Please have this section completed by your regular treating doctor that you have seen for this condition.

Patients Details: (Please print)

Title: First name(s):

Last name:

Address:

Suburb: State: Postcode:

Age: Date of brith: / /

Date of injury: / /

Date you were first consulted: / /

Date diagnosed: / /

Date incapacity commenced: / /

Date claimant was first aware of sypmtoms: / /

Are you the claimant's usual doctor: Yes □ No □

If yes, how long have they been attending your practice: Years: Months:

Please list dates of all consultations in relation to the patient's condition:

1. / /	2. / /	3. / /	4. / /
5. / /	6. / /	7. / /	8. / /

Injury/sickness details:

Please provide your diagnosis of their condition:

Please provide an outline of their symptoms:

In your opinion, what caused the current condition:

Please provide an outline of past treatment :

Please outline your recovery/treatment plan:

History:

In your opinion, is the injury work related? : Yes □ No □

Estimated date of return to work on restricted duties: / /

Estimated date of return to work on normal duties: / /

Is the patient's current condition related to any previous injury? Yes □ No □

If so, did you treat the patient for the injury? Yes □ No □

Has the claimant been referred to a specialist for his/her problems?: Yes □ No □

If Yes, could you please supply the contact details?

Name:

Address:

Suburb: State: Postcode:

Ph: ( ) Fax: ( )

In your opinion, does the patient require surgery for the condition?: Yes □ No □

If yes, has the patient already undertaken the surgery?: Yes □ No □

Date surgery was undertaken: / /

Medication/Treatment:

Has the claimant been taking medication for their condition?: Yes □ No □

If yes, please state the medication and the date prescribed:

Date: / / Medication:

Date: / / Medication:

Date: / / Medication:

Date: / / Medication:

Have you advised the patient, that their condition no longer requires any treatment or ongoing medical supervision, including the use of any prescribed medication? Yes □ No □

If Yes, on what date was that advice given?: / /

What is your prognosis?

Doctor's Authority

I, Title: First name(s):

Last name:

Of, Practice:

In the state of: being a registered medical practitioner, have examined the above named patient and certify the following to be a true description of his/her condition:

And I further certify that the patient was totally disabled from following his/her usual duties:

From: / / To: / / (inclusive)

Signed:

Date: / /

Qualifications:

Address:

Suburb State: Postcode:

Phone: ( ) Fax: ( )

Email:

Please note: Australian Income Protection is not liable for the costs associated in the completion of this section.