Personal Accident/Illness Supplementary Claim

QBE Insurance (Australia) Limited ABN 78 003 191 035 AFSL 239 545

Return the completed form to your Financial Services Provider or mail to QBE Insurance, GPO Box 4108, Sydney NSW 2001 or accidentandhealth@qbe.com

Policy number		**Claim number**	

Note: **Total disablement** is the total disablement of the Insured Person from carrying out all the normal duties of his or her usual occupation. **Partial disablement** is, in the case of injury, the partial disablement of the Insured Person from carrying out the normal duties of his or her occupation.

Claimant details

Name of insured						
Name of insured person						
Postal address						
			State		Postcode	
Date of last medical attendance *(dd/mm/yyyy)*						
State how long you have been:	totally disabled	from *(dd/mm/yyyy)*		to *(dd/mm/yyyy)*		
	partially disabled	from *(dd/mm/yyyy)*		to *(dd/mm/yyyy)*		

Medical certificate (to be completed by attending physician)

1. Are you still attending the patient? Yes ☐ No ☐

2. What are their present symptoms?

3. State how long they've been:

i) totally disabled	from *(dd/mm/yyyy)*		to *(dd/mm/yyyy)*		
ii) partially disabled	from *(dd/mm/yyyy)*		to *(dd/mm/yyyy)*		

4. If they are still disabled, when will the patient be able to resume:

• one or more of the material tasks of their occupation?	Date *(dd/mm/yyyy)*		Time	am / pm
• all of the tasks of their occupation?	Date *(dd/mm/yyyy)*		Time	am / pm

5. If the patient has recovered, when was the patient able to resume:

• one or more of the material tasks of their occupation?	Date *(dd/mm/yyyy)*		Time	am / pm
• all of the tasks of their occupation?	Date *(dd/mm/yyyy)*		Time	am / pm

A final medical certificate is required showing the actual date the patient has resumed work.

6. Are there any further remarks which may assist in assessing this condition?

7. General remarks

Medical certificate (to be completed by attending physician)

Attending physician name		Qualification			
Address					
		State		Postcode	
Telephone number					
Signature		Date *(dd/mm/yyyy)*			

Privacy

Our Privacy Policy describes how we collect, disclose, store and use personal information as well as how to access it, correct it or make a complaint.

When we say personal information we may also mean sensitive information such as health information, criminal history or professional memberships that's relevant to us issuing, administering or managing products or providing services and the terms on which we will do these things. We use personal information to issue, administer and manage products and provide services. You can view our Privacy Policy at **www.qbe.com.au/privacy**, or to obtain a copy by phoning us on 133 723 or requesting it from our authorised representatives or service providers.

We may share your information with other QBE Group companies, our authorised representatives and service providers, each of which may be based outside of Australia.

By giving us personal information you consent to us collecting, disclosing, storing and using it in accordance with our Privacy Policy. If you give us someone else's personal information you confirm you've obtained their consent to do so.

If you don't provide all of the personal information we've requested we may be unable to issue, administer or manage products or provide services.

Declaration and authorisation

The information and answers given above are true, correct and complete in every detail.

1. I/We understand the claim may be refused if information is not true or is withheld.
2. I/We authorise QBE to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

Medical Authority: I authorise any hospital, physician or other person who attended me, to give QBE or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

A photocopy of this authorisation will be considered as effective and valid as the original.

Signature of Insured Person (Claimant)	1.		Date *(dd/mm/yyyy)*	
Signature of Insured Person (Claimant)	2.		Date *(dd/mm/yyyy)*	

Please check that this form has been fully completed as any omissions may delay your claim.