CLAIM FORM

New Zealand Injury and Sickness

EXT194

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

Call ATC for Assistance Toll Free on 0800 300 143

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

2. Your **medical practitioner** completes Section B. A medical practitioner is either a general practitioner (GP) or a specialist. It does not include allied health professionals such as a physiotherapist, chiropractor, or nurse.

3. Your **employer** completes Section C and includes a 12 month pay reporting substantiating your average weekly earnings. Section C is **NOT** required for FENZ employees (including firefighters).

   Important: Please submit Section A and Section B without delay to allow ATC to commence the assessment of your claim while waiting for Section C to be completed by your employer.

4. If you went to hospital following an injury, attach a copy of the hospital admission notes.

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. Post or scan and email your completed form to us as follows:

   Post: ATC Insurance Solutions Pty Ltd
   Level 4, 451 Little Bourke Street, Melbourne Vic 3000
   Email: claims@atcis.com.au (preferred method)

Important Information

Please read the following information carefully, prior to completing this ATC Insurance/Protect claim form.

1. **Assistance with Completing the Claim Form**
   - Call our dedicated Protect claims team Toll Free on 0800 300 143 during Australian business hours.
   - Union members can also contact their union directly for assistance.

2. **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.

3. **Waiting Periods**
   - All Protect insurance claims have a waiting period, during which no benefits are payable.
   - Please check your enterprise agreement or contact Protect or ATC to confirm your applicable waiting period.

4. **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.

5. **Additional Documentation Required**
   - 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.
   - Injuries Involving a Bone Fracture
     - Some 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.
   - ACC Top-Up Claims
     - Please provide us with the relevant details of your accepted ACC claim including a copy of ACC's 'Payment Notification' letter.
     - Throughout the duration of an accepted ACC top-up claim, we will require copies of payment notification letters showing the payments made to you by ACC.
     - If your Injury occurred while playing amateur sport, additional information may be required.

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 ◯ Other ◯ Date of birth ____/____/_____ Height _____cm Weight_____kg

Home telephone_____ Mobile_____

Email_____

Street address _____

Suburb_____ City_____ Postcode_____

Postal Address (if different from above)_____

Suburb_____ City_____ Postcode_____

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

Employment Details

Name of employer_____

Employed since____/____/_____ Occupation/Job title_____

Employee ID (if applicable)_____

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_____

Account no._____

Injury Statement ➲ SECTION A continued

IMPORTANT: You must first lodge a claim through the ACC before submitting your claim to ATC Insurance. Top-Up benefits may be available under the Policy.

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

_____

Sickness Statement ➲ SECTION A continued

Only complete this section of the claim form if your claim relates to an Sickness

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

_____

Other Insurance and Declarations ➲ SECTION A continued

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

1a. Accident Compensation Corporation Yes ◯ No ◯

1b. Sports club or recreation centre's income protection policy Yes ◯ No ◯

1c. Any other insurance policy (eg travel) Yes ◯ No ◯

If Yes, please provide the following details:

Claim number _____

Case manager name _____

Case manager's direct phone number _____

Case manager's direct email address_____

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_____ City_____ 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 2020*. 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 Accident Compensation Corporation 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 Toll Free on 0800 300 143 or write to us at the address given on page one.

Authority and Declaration

I hereby authorise any hospital, physician, insurer, Accident Compensation Corporation, 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 Accident Compensation Corporation 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:

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: 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 ◯ Other ◯ 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 cause of the condition (eg describe the incident that resulted in an injury)?

_____

8. Do you believe the claimant's condition was caused by, or has arisen from, their employment?

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 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 _____

City_____Postcode_____

Signature _____Date ____/____/_____

AFFIX STAMP HERE

SECTION C ➲ Employer's Statement
(Not required for FENZ employees including firefighters)

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

Important: Please submit Section A and Section B without delay to allow ATC to commence the assessment of your claim while waiting for Section C to be completed by your employer.

Company name _____

Project name (if applicable)_____

Telephone_____ Fax_____ Email_____

Street address _____

Suburb_____ City_____ 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. To the best of my knowledge, the claimant's injury or sickness is NOT work-related? Yes ◯ No ◯

3a. Is the claimant entitled to lodge an Accident Compensation Corporation claim for this injury or sickness? Yes ◯ No ◯

4. If a Accident Compensation Corporation or similar claim are applicable, please provide details (including name of the case manager claim/policy number and contact details)_____

   _____

5. Date the claimant commenced with the company _____/_____/_____

5a. Claimant's current work status Full time ◯ Part time ◯ Casual ◯ Contractor ◯

   Employment terminated _____/_____/_____ Employment to be terminated _____/_____/_____

5b. If the claimant's employment has been/will be terminated, please advise reasons_____

   _____

6. If the claimant is medically certified as fit to perform alternative duties, are you prepared to offer suitable duties? Yes ◯ No ◯

6a. If Yes, please provide details of those duties _____

7. If the claimant is medically certified as fit to perform full duties at reduced hours, are you prepared to offer these duties?

   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, it is possible a fraudulent act has been committed that may result in prosecution.