Personal Accident and Sickness

Claim Form

RYNO INSURANCE
We go the extra mile

Motor | Liability | Accident & Sickness

Call **1300 650 670** or email **claims@rynoinsurance.com.au**
rynoinsurance.com.au

Personal Accident and Sickness Cover Claim Form

IMPORTANT INFORMATION

We act upon your claim as soon as we receive this form. You can help us in the assessment of your claim, if you:

1. Complete this form in full. Supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents as indicated may result in a delay in processing your claim.
2. Provide a comprehensive description of the circumstances of the accident/injury or the sickness.
3. If this claim form does not provide enough space, please use a separate piece of paper and attach as supplementary information.
4. When all information has been completed, please forward the claim form to Ryno Insurance Services.

PERSONAL DETAILS

Claimant Name				
Postal Address				
			Postcode	
Telephone No.			Mobile No.	
Email Address			Facsimile No.	
Date of Birth		Height	Weight	
Occupation/Duties				
Employer's Name			Telephone No.	
Location/Department				

FOLLOWING CLAIM ACCEPTANCE BY YOUR INSURER, PLEASE ADVISE PREFERRED METHOD OF PAYMENT

☐ Direct Payment ☐ Cheque *If cheque selected, please nominate Payee name*

If Direct Payment selected, please supply the following information (alternatively, supply a deposit slip noting the following information)

Bank		Account Name	
BSB Number		Account Number	

STATEMENT OF CLAIM *(to be completed by the claimant)*

1. When did the accident occur or when did you first become aware of your sickness?

   Date _____ Time _____ am/pm

2. What is or was the date of the first day you were unable to work? _____

3. In your own words, please provide a FULL description of how the injury occurred or how you became aware of the sickness

4. If injury, please describe exactly what you were doing at the time of your injury (ie.how did injury happen) and where the injury occurred i.e. street name, suburb, etc. _____

5. Please state when you first became aware of symptoms before consulting your GP or Specialist

6. What medical practitioner(s) did you consult?

   Name _____ Date of Visit _____

   Address _____ Telephone No. _____

   Name _____ Date of Visit _____

   Address _____ Telephone No. _____

   Name _____ Date of Visit _____

   Address _____ Telephone No. _____

7. What is the name, address and phone no. of your usual doctor? (Family General Practitioner)

   Name _____ Date of Visit _____

   Address _____ Telephone No. _____

   Number of years treated by this Doctor _____

STATEMENT OF CLAIM *(to be completed by the claimant)*

8. Have you ever suffered from this or a similar condition in the past? If yes, please provide details and dates

Date Details

Date Details

9. During the 24 hours before the injury, did you consume alcohol or drugs?
If yes, please state types, quantities and amount of time between last consumption and injury occurring ☐ Yes ☐ No

10. Were Police in attendance as a result of this accident? ☐ Yes ☐ No

If yes, please provide a copy of their report or the attending officer's name and Police Station

Attending Officer's Name Police Station

11. Please provide names and addresses of any witnesses

Name Contact No.

Address

Name Contact No.

Address

12. Was hospitalisation required? If yes, you must obtain and provide a copy of the ED/Triage report)

Name of Hospital Confined Dates From

To

13. Was the use of an ambulance required? ☐ Yes ☐ No

STATEMENT OF CLAIM *(to be completed by the claimant)*

14. Are you making, or are you entitled to make a claim in respect of this injury or sickness for any of the following?

Sick Leave	☐ Yes	☐ No
Third Party Insurance (Motor Vehicle Accident)	☐ Yes	☐ No
Other Insurance (Journey/Travel/Private Health Insurance)	☐ Yes	☐ No
Centrelink or other Government Benefits	☐ Yes	☐ No
Worker's Compensation (Work Related Injury/Sickness)	☐ Yes	☐ No
Superannuation Policy (Income Protection Cover)	☐ Yes	☐ No

If yes, please provide details including Policy or Claim Number (and dates where applicable)

15. Have you ever made a previous claim in respect to Accident or Sickness insurance? ☐ Yes ☐ No

If yes, please provide details including Insurer and Claim Number

Insurer _____ Claim Number _____

Insurer _____ Claim Number _____

16. Have you engaged in any other income earning employment since you became disabled? ☐ Yes ☐ No

If yes, please provide details (Name of Employer and pay slips)

Employer _____ Contact No. _____

Employer _____ Contact No. _____

Employer _____ Contact No. _____

Employer _____ Contact No. _____

Claimant Authority and Consent Declaration

I declare I am the person named on this form or I have a power of attorney to act on the Claimant's behalf. I declare that the information provided in this form, to the best of my knowledge and beliefs are true and correct and if any answers to the questions completed in this form are not in my handwriting. I have certified that I have checked them and they are also correct.

I understand that if I have made or make any false, misleading of fraudulent statements, conceal or intentionally withhold relevant information for the assessment or ongoing review of this claim, Ryno Insurance Services may:

- Refuse to pay this claim;
- Recover benefits paid that were based on false or misleading information I provided;
- Be obliged to refer such case to relevant Authority.

I declare and authorise that I have read and understood the Privacy Information provided with this form and I understand that my personal and sensitive information, may be disclosed to other parties as advised below and approve these purposes.

I hereby authorise and direct any medical attendant, Doctor, Hospital or other medical or health service to divulge to Ryno Insurance Services, its representatives or any legal tribunal, and to release at any time details of my personal medical history, including referrals to or treatment by

any other Practitioners, any health or other information acquired with regard to myself for the purposes of allowing Ryno Insurance Services to assess my claim or assess any new, additional insurances (including re-instatements).

I also authorise my current and any previous Employer to release to Ryno Insurance Services any personal or health information requested to facilitate an assessment of my claim. Under Government Privacy Legislation, I may access a copy of any reports provided to Ryno Insurance Services.

I authorise Ryno Insurance Services to obtain from Medicare such portion of my claims history deemed necessary by Ryno Insurance Services to properly assess my claim.

I also authorise the Institutions listed below to provide

to Ryno Insurance Services any health and other personal information that Ryno Insurance Services considers essential and/or reasonable to further assess or evaluate my claim. I further authorise Ryno Insurance Services to contact, release and obtain information it requires to assess my claim for benefits, from those other sources it consider necessary including, but not limited to the following:

- Any Doctor, ambulance, hospital or other health service provider.
- My employer, previous employer's accountant/s and/or Financial Advisors and/or Union Delegate or Representative.
- Medicare, the Insurance Commission including PBS RECORDS.
- Any Insurance Company, including Workers Compensation Insurer.
- Insurance or financial reference agencies, re-insurers, financial institutions including banks, credit unions, building societies, mortgage providers, finance companies, (and Claims investigators, Private Investigators and Detectives and Forensic Accountants.
- Government Agencies, including, but not limited to Centrelink, Australian Taxation Office, Australian Securities and Investments Commission, Department of Veterans' Affairs and Department of Immigration and Multicultural and Indigenous Affairs.
- Any Federal, State or Territory Police Department.
- Traffic Accident Commission (Victoria), State and Territory Roads and Traffic Authorities, Queensland Transport, Vic Roads Registration and Licensing Office, Transport South Australia.
- Any other Institutions that hold my personal information.

I understand that Ryno Insurance Services may be required to submit all documentation to a mediator, Solicitor, Complaints Resolution Tribunal or Court or to any other person necessary for claims determination purposes including the Trustee of any Superannuation Plan.

I understand a determination of my claim may no t be possible if i withhold consent and authority for Ryno Insurance Services to seek personal and/or health information in relation to my claim.

I agree that a scanned, photocopied or faxed copy of this authority shall be considered as effective and valid as the original.

Signature of Claimant

Name of Claimant (please print)

Date / /

INCOME DETAILS *(Delete 1 or 2, whichever is not applicable)*

1. IF SELF EMPLOYED

If the claimant is not an employee (i.e. a self employed contractor), then the gross weekly income derived from the personal exertion of the Insured Person is their usual occupation, after deducting any expenses necessarily incurred in deriving that income averaged over the number of weeks so engaged during the twelve (12) months immediately preceding the date of disablement giving rise to claim, must be supplied

Your Accountant's Name

Address

Telephone no.

Please confirm employment/position status (i.e. Director/Partner/Sole Trader)

2. IF EMPLOYED AS A WAGE EARNER – TO BE COMPLETED BY YOUR EMPLOYER

I hereby certify that

has been unable to attend their usual occupation with the company as a result of an injury/injuries/sickness suffered on / /

a. What was the employees last day at work? / /

b. When is the employee expected to/did resume duties? / /

c. If the claimant is an Employee, please complete the attached Declaration of Pre-Disability Earnings Form to confirm earnings across the number of weeks so engaged during the fifty two (52) weeks immediately preceding the date of disablement giving rise to this claim

d. When did the claimant commence employment with the Company?

e. Please describe the claimants usual occupation

f. Has the employee lodged or intend lodging a Worker's Compensation Claim? ☐ Yes ☐ No
If yes, please provide copy confirmation of acceptance or rejection (letter) from the insurer

g. Is there any additional information you would like to provide in relation to the submission of this claim? ☐ Yes ☐ No

EMPLOYER/COMPANY DETAILS

Name of Company

Postal Address

Postcode

Signature of Supervisor or Paymaster

Name of Supervisor or Paymaster

Telephone No.

Fax No.

Email Address

DECLARATION OF PRE-DISABILITY EARNINGS

Employer – please note. It is your responsibility to complete this form and calculate the average weekly earnings in line with the policy definition of "earnings" as described below

WEEKLY EARNINGS DURING THE 52 WEEKS PRIOR TO INCAPACITY – for Employees

Employees Name

PLEASE READ THE FOLLOWING DEFINITION OF "EARNINGS" FOR EMPLOYEES BEFORE COMPLETING THIS FORM:

"If an employee, the gross weekly rate of pay inclusive of bonuses, commission, overtime payments and all other allowances, from the personal exertion of the Insured Person in their usual occupation, averaged over the number of weeks so engaged during the twelve (12) month period immediately preceding the date Disablement commences."

Gross Annual Income – $

Average Gross Weekly Rate of Pay – $

To avoid delays, please ensure that this form is fully completed with ALL "Earnings" as detailed in the definition above. Please note the Weekly Benefit entitlements will be calculated upon the information/declaration that your provide.

I sincerely DECLARE that to the best of my knowledge the information provided above is true, accurate and complete.

Payroll Officer's Name

Date / /

Payroll Officer's Signature

DOCTORS STATEMENT *(Please print legibly – this form cannot be accepted otherwise)*

IMPORTANT

1. The patient is responsible for any fee for this statement
2. This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist or any other Allied Health Professional)
3. Dashes or blank spaces are not acceptable – claim cannot be considered if all information is not provided

Patient's Full Name

Patient's Date of Birth

1 a) What date were you first consulted by the Patient in connection with the present condition?

b) How long had the patient been experiencing symptoms prior to consulting you for the first time?

c) When do you believe this condition manifested?

d) How long has this patient been under your care? (Please state months and/or years)

2 a) What is the diagnosis and proximate cause of the present sickness or injury?

b) If X-Ray examination or other tests have been made, state finding and/or attach copy of reports

3 a) Is the current condition in any way related to their work? ☐ Yes ☐ No

b) Would you support a Worker's Compensation Claim? ☐ Yes ☐ No

Please explain why/why not?

4 Has the patient **previously** suffered from the same or a **similar condition**? ☐ Yes ☐ No

a) Date of consultations / / / / / / / / / /

b) What was the diagnosis/prognosis of previous condition?

c) Was this occurrence/recurrence expected? If yes, please explain why ☐ Yes ☐ No

5 Is there anything in the patient's medical history that may have contributed or aggravated, either directly or indirectly to the injury/sickness? If yes, please provide details below ☐ Yes ☐ No

6 Is there anything in the patient's medical history that may be likely to delay the recovery? If yes, please provide details below and advise how long recovery may be delayed ☐ Yes ☐ No

7 Please provide summary details of all past and present medical advice and treatment provided to the patient in respect of his/her current disablement

8 Have you referred the patient to other specialist services or treatment? If yes, please provide details and a telephone contact number ☐ Yes ☐ No

Telephone No.

Telephone No.

Telephone No.

9 Has the patient continued to follow medical advice? If no, please provide details ☐ Yes ☐ No

10 If the patient has already been hospitalised, please give name of hospital and dates

Dates From / / To / /

Dates From / / To / /

11 Is there any reason or evidence to suggest the Patient was under the influence of intoxicants at the time of the accident? ☐ Yes ☐ No

12 If yes, do you believe the influence of the intoxicants has significantly contributed to or caused the injury or sickness onset to occur? ☐ Yes ☐ No

13 a) When was the patient obliged to cease work?

b) When did or when to you realistically expect the Patient to resume work?

i) Full unrestricted duties?

ii) Modified duties, if necessary?

iii) Normal duties in reduced capacity (ie. restricted hours)

If unable to return to work in a partial capacity, please provide an explanation

14 I hereby certify that the patient has been and/or will be totally disabled from carrying out his/her duties as follows:

Dates From / / To / / (inclusive)

Additional remarks: (e.g. Prognoses, life expectancy, occupational rehabilitation, surgery waiting list)

Doctor's Name

Doctor's Address

Telephone No. Fax No.

I hereby certify that I have personally examined the above-named patient and that in my opinion the statements made in the Statement of Claim section of this Claim Form are consistent with the patient's injury or sickness

I have read and accept the Privacy statement provided with this Claim Form Date / /

Signature Qualifications

Privacy Policy

Ryno Insurance Services is committed to protecting the privacy of the personal information Your Provide to Us in accordance with the Privacy Act 1988 (Cth) and the Australian Privacy Principles.

We collect Your personal information to assess Your application for insurance, administer Your Policy and pay Your claims.

If You do not provide the information that We request, Your insurance applications may not be accepted, or We may not be able to administer Your Policy or a claim. Also, You may breach Your duty of disclosure, the consequences of which are set out in the duty of disclosure section of the PDS.

We may need to share Your information with others to decide whether to accept Your Policy, administer Your Policy and manage and pay Your claims. To allow Us to do this and to otherwise operate Our business, Your personal information may be give to and used by the following:

- The Insurer of this Policy, certain Underwriters at Lloyd's and its own employees and agents. The Insurer is located in the United Kingdom. When Your information is disclosed to the Insurer it will be protected by the Data Protection Act 1998 (UK) which contains similar protection to the Australian Privacy Principles.
- Claims adjusters, lawyers and other people appointed by Us or the Insurer, or on Our behalf or the Insurer's behalf for claims handling purposes.

By submitting Your personal information to Us, You agree to Us using and disclosing Your personal information this way. This consent to the use and disclosure of Your personal information remains valid unless You alter or revoke it by giving Us written notice.

We may also use Your information to notify You about other products or promotions from time to time. We always give You the option of electing not to receive these communications. Please let Us know if You do not wish to receive this information.

If Your details or personal information changes, You should notify Us in writing of changes so We can ensure that information We hold about You is accurate, complete and up-to-date.

For details of Our policy on access to and collection of personal information We hold and how to make a complaint regarding privacy, please download a copy of Our privacy policy from our website: **www.rynoinsurance.com.au**

Complaints regarding privacy can be made to:

The Privacy Officer
Ryno Insurance Service
Po Box 239
Coopers Plains, QLD 4108
Email: privacy@rynoinsurance.com.au

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