Sickness and Accident (Disability)

Claim Form

Policy No.	Period of Insurance: From / / to / /

Section 1: General Information

Full Name of Insured: Surname _____ Given Names _____

Date of Birth: _____ /_____ /_____

Private Address: _____

Postal Address: _____

Name of Employer: _____

Occupation: _____

Telephone: Private: _____ Business: _____ Email: _____

Vehicle Details (make and model): _____ Registration Number: _____

Dealership Vehicle purchased from: _____

Finance Company: _____ Finance Contract No. _____

Amount of Monthly Payment: _____ Outstanding Balance: _____ Date Payment Due: _____

Section 2: General Medical Information

Date of first examination or treatment by medical attendant for this occurrence: _____ /_____ /_____

Name and Address of doctor who first attended you: _____

_____

Name and Address of usual medical attendant: _____

_____

Name and Address of the medical attendant now treating you: _____

_____

Name and Address of other medical attendants for any accident or illness in the last 5 years: _____

_____

Have you engaged in or attended to your usual profession, business or occupation since the date of accident or the date upon which the illness became evident (even if only in a reduced capacity)? ☑ YES ☐ NO

State dates between which you were confined: To Bed: From _____ /_____ /_____ To: _____ /_____ /_____

To House: From _____ /_____/_____ To: _____ /_____ /_____

Section 3: Illness

What is the nature of the illness? _____

When did it first become evident? _____

Have you ever suffered from or sought treatment for the illness in respect of which you are now claiming? ☐ YES ☐ NO

If YES, give details including date you last sought treatment:

_____

Period for which you are claiming: From _____ /_____ /_____ To: _____ /_____ /_____

Section 4: Accident

When did the accident occur: _____ Date: _____ /_____ /_____ Time: _____ AM / PM

State exactly how the accident occurred:

_____

_____

_____

_____

_____

Nature and extent of injuries: (If a limb or an eye, state whether left or right)

_____

_____

_____

Name and address of all witnesses of the accident

Witness #1 Name: _____

Address: _____

Witness #2 Name: _____

Address: _____

Witness #3 Name: _____

Address: _____

Witness #4 Name: _____

Address: _____

Have you suffered from or sought treatment previously for the disability in respect of which you are now claiming? ☐ YES ☑ NO

If YES, give details including date you last sought treatment:

_____

_____

_____

_____

Period for which you are claiming: From _____ /_____ /_____ To: _____ /_____ /_____

PLEASE NOTE

1. If you are claiming for an accident or an illness, then Section 5 must be completed by your Medical Attendant. You are also reminded that any charge for completion of that Report must be borne by you as per the terms of your policy.
2. Your signature is required in Section 7 of this form before lodgement

Section 5: Medical Attendant's Report

Name of Claimant: _____

Occupation: _____

Are you the Claimant's usual medical attendant? ☐ YES ☐ NO

State the exact nature and extent of injuries sustained or all illness/disabilities suffered by the Claimant:

_____

What organs are affected (state whether mild or severe)?

_____

On what date did you first attend the Claimant in connection with his/her present disablement? _____/_____/_____

Was there any external and visible sign of injury? ☐ YES ☐ NO

If YES, give details: _____

In your opinion, would the symptoms have been evident to the Claimant for any length of time?

_____

a. State period that the claimant:

Will be totally unable to attend their usual occupation or business: From _____/_____/_____ To _____/_____/_____

Has been totally unable to attend their usual occupation or business: From _____/_____/_____ To _____/_____/_____

b. When did they or at what date did you expect that the Claimant will be able to resume:

Some part of their work? From _____/_____/_____ To _____/_____/_____

The whole part? From _____/_____/_____ To _____/_____/_____

Has the treatment or medicine prescribed by you been adhered to by the Claimant: ☐ YES ☐ NO

Are you aware of the claimant previously suffering from this condition: ☐ YES ☐ NO

If YES, please provide FULL details:

_____

Has the Claimant previously suffered from any illness which would have contributed to or would have accelerated the occurrence of the Claimants Current medical condition: ☐ YES ☐ NO

If Yes, please provide details: _____

Medical Attendants General Remarks

_____

_____

Name: _____ Qualifications: _____

Address: _____ Post Code: _____

Signature: _____ Date: _____/_____/_____

Section 6: Employment Details

Name and Address of Last Employer: Name: _____

Address:_____

Was this employment Permanent, Seasonal, Contract of Service or of a specific period? _____

Date Employment Commenced: _____ /_____ /_____ Date Employment Ceased: _____ /_____ /_____

Period Employed: _____

Hours worked per week: _____

Section 7: Declaration and Signature of Insured

- I hereby declare that the information I have submitted in relation to this claim is true and correct in every particular;
- In the event that this claim references any Accident, injury or illness, I authorise all medical Professionals to supply Eric Insurance Limited (eric) with my complete medical history including detailed medical reports, clinical notes, examination findings and full details of any period of incapacity that may have arisen from the condition for which treatment was sought;
- I give authority to obtain finance documents from the financiers
- I give authority to obtain employment information from my employers
- I agree to provide any information that is requested by eric that it deems is relevant to assessing this claim; and
- I acknowledge that Eric Insurance Limited may provide, and obtain from, other insurers and/or the Insurance Reference Bureaux personal information relating tot his claim as well as claims I have previously lodged, in accordance with eric's Privacy Policy. I understand that I may request a copy of eric's Privacy Policy at any time or obtain it from eric's website

Signature of Insured: _____ Date: _____ /_____ /_____

Print Name: _____

(A photocopy of this authority has the same effect as the original)

Returning Instructions:

Please complete and return this form to the Postal Address below, together with all documentation requested to:

Eric Insurance Limited

PO Box 9106 Scoresby VIC 3179

claims@ericinsurance.com.au

Claims Enquiries:

Eric Insurance Limited claims officers are available to assist you with any queries relating to your claim.

Please contact our Australia wide phone service on Free Call 1800 999 977 for assistance.

If you have an unresolved complaint or dispute, you should first speak with our Operations Manager.

If you are not able to resolve your concerns with the Operations Manager, you should ask that your query be referred to Eric's Internal Disputes Department.

Eric Insurance Limited

Customer Service 1800 999 977

Email: claims@ericinsurance.com.au