Claim form

Journey

About this claim form

- There are several sections for you to complete in full, as well as some for your employer. If you're self-employed, you'll need to fill in all these sections.
- To avoid delays with your claim, it's important that you provide answers to all the questions, including any additional documentation requested.
- The issue of this form is not an admission of liability.

Helpful instructions

We know that making a claim is often done at a stressful time and understand the importance of processing your claim as quickly as possible. Your claim will be managed by Corporate Services Network (CSN), our trusted claims service provider, who is committed to ensuring your claim is handled efficiently, honestly, and fairly.

Sections 1 to 5	Please **fully** complete Sections 1 to 5 of this claim form, and include: • a copy of your motor vehicle license (front and back) • a copy of the police report (if applicable)
Section 5	Sign the privacy declaration "Medical Authority and Declaration"
Section 6	**If you're an employee**, ask your employer to complete Section 6, and include 12 months payroll history prior to the date of your injury/sickness. **If you're self-employed**, please fill out Section 6 and provide your Tax Assessment Advice from the ATO for the previous financial year as proof of your income.
Section 7	"Medical Practitioner's Statement" is completed by your doctor.
Supporting documents	Attach any supporting documents you have for medical expenses to claim.

Ready to submit your claim form?

If so, please double check that you have followed all of the instructions, then send the completed claim form to ahclaims.au@libertymutual.com

You can fill out the form either electronically or by hand and if you have any questions regarding the completion of this claim form, please contact CSN on +61 2 8256 1770.

Save Print

CORPORATE SERVICES NETWORK

Liberty
c/- Corporate Services Network
GPO Box 4276, Sydney NSW 2001

T: +61 2 8256 1770
F: +61 2 8256 1775
E: ahclaims.au@libertymutual.com

Claim form

1. POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

Employer's name Policy #

Title Given name(s) Male ☐ Female ☐ Prefer not to state ☐

Family name Date of birth

Residential address

Suburb State Postcode

Postal address

Do you consent to us communicating with you by email? Yes ☐ No ☐ Email

Daytime contact number Alternative number

Occupation, trade or profession

Work site/location

Which benefits are you claiming? Weekly benefit ☐ Capital benefit ☐

2. EFT AUTHORISATION

I authorise and request that CSN credit the bank account as indicated below:

For direct/EFT payment
Account holder's name

BSB no ☐☐☐ ☐☐☐ Account no ☐☐☐☐☐☐☐☐☐ Bank

3. DETAILS OF ACCIDENT AND INJURY

Date of accident Time AM ☐ PM ☐

Were you the driver, rider or a passenger? Driver ☐ Rider ☐ Passenger ☐ Other ☐

If other, please provide specific details:

Is your licence currently valid? Yes ☐ No ☐

If no, please explain why? (i.e suspended, cancelled etc.):

What type of vehicle were you in at the time of injury? Motorbike ☐ Car ☐ Truck ☐ Bus ☐ Van ☐ Other ☐

If other, please provide specific details:

Please state the address where accident occurred:

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Type of road condition where incident occurred? Dirt ☐ Bitumen ☐ Concrete ☐ Sealed surface ☐ Other ☐

If other, please provide specific details:

Please describe how the accident occurred:

Where were you travelling to at the time of the event?

Where were you travelling from at the time of the event?

Were you working at the time of the event? Yes ☐ No ☐

When did the event occur? During business hours ☐ After business hours ☐

Did the police attend the scene? Yes ☐ No ☐

If yes, please name the police officer, station and event number

If the police did not attend the scene, was the event still reported to the police? Yes ☐ No ☐

If yes, please name the police officer, station and event number

(If possible, please provide us with a copy of the police report.)

If the event was not reported to the police, why?

Who did the police find at fault for the incident?

N/A ☐ Myself ☐ Other driver ☐ No one ☐ Under investigation ☐

What action was taken by the Police against the person who was at fault for the incident?

N/A ☐ Traffic fine ☐ Court summons ☐ Arrest ☐ TBA ☐

Did the police subject you to any of the following RBT ☐ RDT ☐ Blood test ☐

Were you on any medication at the time of the event? Yes ☐ No ☐

If yes, please provide medication details, the reason for use, and the time it was consumed prior to event:

Were you suffering any illnesses at the time of the event? Yes ☐ No ☐

If yes, please provide details of illness:

Did you consume any alcohol in the six (6) hours prior to the event? Yes ☐ No ☐

If yes, please advise:

Time commenced drinking alcohol Time AM ☐ PM ☐

Time before the incident you ceased drinking alcohol Time AM ☐ PM ☐

Type of alcohol: Beer ☐ Wine ☐ Spirits ☐ Mixed drinks ☐ Other ☐

If other, please provide details:

Approximately how many beverages did you consume?

Where were you drinking? (i.e. home, bar, etc.)

Did you take/consume any drugs and/or prescribed medication of any kind in the six (6) hours prior to the event? Yes ☐ No ☐

If yes, please advise:

Time commenced consuming/taking the drug(s) and/or prescribed medication before event AM ☐ PM ☐

What type of drug(s) and/or prescribed medication were consumed/taken

Approximately how much of the drug(s) and/or prescribed medication consumed/taken?

What were the injuries?

Have you previously been treated for a similar or same injury? Yes ☐ No ☐

If yes, please give details:

4. TREATMENT RECEIVED FOR YOUR INJURY OR SICKNESS

Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

When did you stop work? Time AM ☐ PM ☐

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When did you first obtain treatment from doctor? Time AM ☐ PM ☐

Name of current treating doctor

Clinic name/address:

Name of regular doctor

Clinic name/address:

Date first consulted doctor Date last consulted doctor

How long have they been your regular doctor? Years Months

Was hospital treatment required? Yes ☐ No ☐

If yes, please complete the following regarding your hospital stay (please attach separate sheet if insufficient space):

From	To	Hospital name	Hospital address

Is there any condition (past or present) affecting your current disability? Yes ☐ No ☐

If yes, please give details:

Are you now:

Recovered Yes ☐ No ☐ When did you return to work?

Partially disabled Yes ☐ No ☐ When did you return to work undertaking part of?

Totally disabled Yes ☐ No ☐ When do you expect to return to work?

Have you made, or will you make, or are you entitled to make, a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury? Yes ☐ No ☐

If yes, please provide details below:

	Claim no (if known)	Name	Address
Employer			
Workers' comp/ transport insurer			

Name of your superfund

Superfund membership no

Are you entitled to income protection benefits through your superfund? Yes ☐ No ☐

If yes, have you made a claim? Yes ☐ No ☐

Claim reference number

5. MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither Corporate Services Network (CSN) or Liberty have accepted liability, nor waived any of their rights in respect of any claim arising under the policy.

I consent to CSN and/or Liberty using and disclosing my personal information in accordance with their respective privacy policies and this document. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity to provide to CSN or Liberty such personal information (including health information) as CSN or Liberty in its absolute discretion considers relevant for its assessment of my claim including my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to Liberty and CSN in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not deliberately withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN or Liberty may not be able to process or assess my claim.

I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of claimant Date

Name of claimant

Signature of witness
(any adult person) Date

Name of witness

Privacy Notice

Liberty Mutual Insurance Company, Australia Branch (ABN 61 086 083 605) incorporated in Massachusetts, USA (the liability of members is limited) (**Liberty**) is part of the Liberty Mutual Group headquartered in the United States.

Liberty and Corporate Services Network (**CSN**) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information. For the purposes of this Privacy Notice, 'we', 'us' or 'our' refers to, if the context permits, both Liberty and CSN.

We collect personal information to provide insurance products and services, manage claims and support related business operations. This may include information collected from insurance brokers, intermediaries, or directly from you. If you do not provide the personal information requested, we may be unable to offer the appropriate type or level of service.

If you provide us with personal or sensitive information about another individual, you must ensure they are aware of this notice and have consented to the disclosure. If you have not done so, please inform us before sharing their data. Your personal information may be disclosed to our related entities, reinsurers, insurance intermediaries, loss adjusters, legal and professional advisors and other service providers. We may also store your information with third party cloud or electronic storage providers.

Some recipients may be located overseas in the United States, Canada, United Kingdom, European Union, India, China, Australia, Hong Kong, Singapore and Malaysia. Where reasonably necessary, your information may be transferred to countries without comparable data protection laws to deliver the services you request. By engaging with us, you consent to these cross-border transfers unless you notify us otherwise in writing.

We are committed to protecting your privacy and ensuring transparency in how we use your personal information. As part of this commitment, we confirm Liberty does not currently use automated decision-making (**ADM**).

You may access or seek correction of your personal information, make a privacy complaint, or raise any queries by contacting Liberty's Privacy Officer and/or CSN's Privacy Officer: privacy.officer.ap@libertymutual.com. If you require a physical mailing address, please contact the Privacy Officer via email.
CSN: privacy@csnet.com.au

For more information, and to view the relevant privacy policy for your jurisdiction, visit: Australia Privacy Policy.

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6. TO BE COMPLETED BY YOUR EMPLOYER

Employer's name

This is to certify that

has been unable to attend their occupation as a result of injury or sickness from until

Their average gross weekly salary (as defined by the policy wording) averaged over the previous 12 months at the time of this injury/sickness was $

Employee's occupation

Type of employment Permanent full time ☐ Permanent part time ☐ Casual ☐ Fixed term/contract ☐

Are they still employed? Yes ☐ No ☐ If no, please provide the last date they were employed

Their sick leave entitlement as at the date of injury or illness days

They have been employed since

Has a claim for workers' compensation been lodged? Yes ☐ No ☐

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission/CTP? Yes ☐ No ☐

Signature of supervisor or manager

Name of supervisor or manager (please print)

Telephone number Date

7. MEDICAL PRACTITIONER'S STATEMENT TO COMPANY

The claimant is responsible for any fee for this statement. This form should be fully completed and returned promptly

Patient's name | Date of birth

Height | Weight

Diagnosis (if fracture or dislocation, describe nature and location i.e. simple, compound):

Cause:

Is this condition | An injury ☐ | or an illness ☐

Does the patient have any other injury or illness that is contributing to the condition? | Yes ☐ | No ☐

Please provide details:

Is condition due to injury or sickness arising out of the patient's employment? | Yes ☐ | No ☐

Please provide details:

Date of onset/first symptoms?

When did the patient first consult you for this condition?

Has the patient ever had the same or similar condition? | Yes ☐ | No ☐

From when and diagnosis:

Name of patient's usual doctor/medical practice

How long have you been the patient's usual doctor/medical practice?

If the patient was hospitalised please provide | Admission date | Discharge date

Name of hospital

Has the patient had surgery, or is it anticipated? | Yes ☐ | No ☐

Please provide details:

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Date performed or anticipated

Give name of hospital

Please outline all treatment received to date in the management of your patient's condition. Please include any relevant medical documents, reports or investigative scans.

Was the patient referred by you or to you? Referred ☐ Referring ☐

Provide details

Doctor's details

Date of referral

Is the patient still disabled?

No ☐ when did the patient return to work?

Yes ☐ how long will the patient be:

– totally disabled (unable to perform any part of their occupation) from to

– partially disabled (able to perform part of their occupation) from to

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, workers' compensation insurer, social security, sports body or any other insurance body? Yes ☐ No ☐

Name of company/contact/claim number

Signature of medical practitioner

Name and qualifications (print)

Address

Telephone Date

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