Claim form

Journey

At Liberty, we're here to support you throughout the claims process. We're committed to handling your claim with efficiency, honesty and fairness.

This claim form includes several sections for you to complete. To help us assess your claim promptly, please answer all relevant questions and provide the requested supporting documentation..

Helpful instructions

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.

Neither the issue of this form nor its completion is to be deemed a provision of indemnity or an admission of liability.

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 ClaimsAusAH@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 us on +61 2 9959 4307.

Save Print

Liberty
c/- GPO Box 4276, Sydney NSW 2001

T: +61 2 9959 4307
F: +61 2 9959 4308
E: ClaimsAusAH@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 Liberty 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:

Liberty means Liberty Mutual Insurance Company, Australia Branch (ABN 61 086 083 605) incorporated in Massachusetts, USA (the liability of members is limited). Claims are managed by Gallagher Bassett Accident & Health Pty Ltd (AR No. 001294637) as Authorised Representative of Gallagher Bassett Services Pty Ltd (AFSL No. 530867).

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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 consent to Liberty and their representatives using my personal information, health and other sensitive information and sharing it with their affiliated companies, service providers, insurance intermediaries, insurers, reinsurers, investigators, claims assessors, and other relevant third parties, only to the extent required for processing and handling my claim including assessment of eligibility and the provision of policy benefits, risk assessment, policy administration, and other insurance and related business purposes described in Liberty's privacy policy. I understand there may be circumstances in which I shall be contacted if my further consent is required to collect, use or disclose my personal information.

I authorise each person or entity including my service provider, healthcare provider, public authority, employer, witness, agent, next of kin, and another third party, to provide to Liberty and their representatives such information about me as may be requested in connection with my claim.

I appoint Liberty to do such act/s and execute such document/s on my behalf as is necessary or expedient to give effect to the consent and authorisation given by me in this form.

This consent, authorisation and appointment will remain in effect until completion of the relevant purpose or until altered or revoked (in whole or in part) by me, which I am free to do at any time by notice. However, I understand that without the consent, authorisation and appointment, Liberty's ability to provide services to me may be limited.

I confirm that any information provided by me is true, correct, complete and not misleading, and if I provide information about others, I will only do so with their knowledge and consent.

I understand that unless expressly otherwise stated in writing, neither Liberty or their representatives make any representation, accept any liability or claim or waive any right or defence.

By signing below, I give effect to the declarations, consent, authorisation and appointment set out in this form.

Signature of claimant	Date
Name of claimant	

Signature of witness (any adult person)	Date
Name of witness	

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Privacy Notice

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

Liberty Australia's head office contact details are:
Mailing address: The Privacy Officer, Liberty Mutual Insurance Company, Australia Branch, Level 38, Governor Phillip Tower, 1 Farrer Place, Sydney NSW 2000
Phone: +61 2 8298 5800

Liberty is bound by the Privacy Act 1988 (Cth) and the Australian Privacy Principles when it collects and handles your personal and sensitive information.

We collect personal and sensitive information to provide insurance and related products and services. This may include information relating to your identity, personal circumstances, employment, health, personal or professional risk information, insurance requirements and similar information collected from you, the insured, policyholder, insurance broker or another intermediary. Liberty will use your information for activities such as identity check, underwriting, claims management, eligibility assessment, provision of policy benefits, risk assessment, policy administration, reserving, settlement, business analysis, information management and automation, and other insurance and related business purposes.

If you provide Liberty with your sensitive information for insurance purposes or if you instruct a third party to do so, you consent that Liberty may handle your sensitive information as is necessary for these activities. You may withdraw your consent at any time. If we do not obtain the required information, we may be unable to provide appropriate cover or service.

If you provide Liberty 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 Liberty before sharing their information.

Your personal information may be disclosed where it is lawful, necessary and proportionate to do so, to Liberty's affiliated companies, our service providers, brokers and other insurance intermediaries, insurers, underwriters, reinsurers, investigators, claims assessors, loss adjusters, legal and professional advisors, parties to a claim, health service providers, witnesses, policyholder, beneficiaries, public authorities, and other relevant third parties. Some recipients may be located overseas in Canada, China, European Union, Hong Kong, India, Malaysia, Singapore, United Kingdom, and the United States. We take reasonable steps such as binding the recipient to appropriate contractual terms to ensure that your personal information remains protected in these countries.

We rely on enterprise technologies including artificial intelligence for various tasks including data extraction, summarisation, analysis, process automation and others. However, decisions based on your personal information that affect you are made by our staff and not by automated means.

You may access or seek correction of your personal information, make a privacy complaint, or raise any queries by contacting Liberty's Privacy Officer: privacy.officer.ap@libertymutual.com.

For more information, please visit our Privacy Policy.

Please see below the details of our claims service provider:
Company name: Gallagher Bassett Accident & Health Pty Ltd (Company)
Email: privacy@gbtpa.com.au Telephone: 1300 975 609 Mail: GPO Box 4276, Sydney NSW 2001
Privacy policy: https://www.gallagherbassett.com/au/global-privacy-notice/

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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