Claim form

Group Personal Accident & Sickness

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, including either the sickness or injury statement.
Section 7	Sign the privacy declaration "Medical Authority and Declaration".
Section 8	**If you're an employee**, ask your employer to complete Section 8, and include 12 months payroll history prior to the date of your injury/sickness.
	If you're self-employed, please fill out Section 8 and provide your Tax Assessment Advice from the ATO for the previous financial year as proof of your income.
Section 9	"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

Save Print

Liberty
c/- GPO Box 4276, Sydney NSW 2001

T: +61 2 9959 4307
F: +61 2 9959 4308
E: ClaimsAusAH@libertymutual.com

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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

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. INJURY CLAIM

Date of injury | Time | AM ☐ PM ☐

Address where injury occurred

Were there any witnesses to the incident? Yes ☐ No ☐

If yes, please provide their details below:

Witness/s name

Witness/s address

Please describe how the injury 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).

What were the injuries suffered?

Have you previously been treated for any serious injury? Yes ☐ No ☐

If yes, please provide details below:

Provide details of any previous claim/s made for any previous injury against any insurance company:
(please attach a separate sheet if insufficient)

During the 24 hours before the injury, did you drink any alcohol or take any drugs and/or prescribed medication? Yes ☐ No ☐

If yes, please state the type/s and quantities:

4. TO BE COMPLETED IF DISABILITY IS AS A RESULT OF A SICKNESS CLAIM

Describe the nature of the sickness:

When did the sickness begin?

Have you had this complaint before? Yes ☐ No ☐

If yes, when? and how long were you disabled?

5. 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.

Was hospital treatment required? Yes ☐ No ☐

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

From	To	Hospital name	Hospital address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctor's name	Address	Telephone number

When did you stop work?	Time	AM ☐	PM ☐
When did you first obtain treatment from doctor?	Time	AM ☐	PM ☐
Name of doctor			
Address			
Is this doctor still treating you for the injury/sickness?		Yes ☐	No ☐
Is this doctor your regular doctor?		Yes ☐	No ☐

If no, please give details:

Name of regular doctor	
Address of regular doctor	

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

Have you made, or will you make, a claim for benefits under any Worker's Compensation Act or Transportation Act because of this injury/sickness?	Yes ☐	No ☐

If yes, please give details:

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

Are you entitled to claim benefits for this Injury/sickness from other insurers, persons, company, health fund, friendly society or government? Yes ☐ No ☐

If yes, please give details:

Name	Address

6. TO BE COMPLETED BY AUTHORISED PERSON MAKING A CLAIM FOR DEATH BENEFIT

Name of person completing the form

Telephone Email

Company name (if applicable)

Address

Relationship with deceased Employer ☐ Next of kin ☐ Executor ☐ Lawyer ☐ Other ☐

If next of kin, or other, please state relationship

The following items must be included with this claim.
– Certified copy of original death certificate
– Certified copy of original birth certificate
– Copy of the Coroner's depositions of findings (if applicable)

Was a coronial inquest held, or is one being held? Yes ☐ No ☐

If yes, give details below:

7. 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.

Your signature	Date
Your name	

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

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8. 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 gross weekly salary (as defined by the policy wording) at the time of this injury/sickness was $

Has your employee's last 12 months payroll history been attached with this report, and if not, please provide Yes ☐ No ☐

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

They have been employed since

Please confirm if they are still an employee Yes ☐ No ☐

Please confirm the date they were no longer employed

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 insurer? Yes ☐ No ☐

Signature of supervisor or manager

Name of supervisor or manager (please print)

Telephone number Date

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9. MEDICAL PRACTITIONER'S STATEMENT

This form should be fully completed. The patient is responsible for any fee incurred.

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 ☐ | A sickness ☐

Does the patient have any other injury or sickness 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:

Was the disability sports related? | Yes ☐ | No ☐

Please provide details:

Date of onset/first symptoms?

When did the patient first consult with you for this condition?

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

If yes, please state when this occurred and the diagnosis:

Name of patient's usual doctor/medical practice

Length of time attending the usual doctor/medical practice?

If the patient was hospitalised, please provide the admission date | and discharge date

Name of hospital

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

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Please provide details:

Date performed, or anticipated to be performed

Name of hospital

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 ☐

Please 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 their current disability to be issued to any other insurance company, accident commission, workers' compensation insurer, government body, sports body or any other insurance body? Yes ☐ No ☐

If yes, please provide the name of the company, the contact and claim number:

Name of company

Contact number Claim number

Signature of medical practitioner

Name and qualifications (print)

Address

Telephone Date

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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/

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