# Claim form

# Voluntary Worker

**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, including email address details, the injury statement and please do not attach accounts paid or part paid by Medicare |
| Section 6 | Your organisation completes the section "Organisation Declaration". |
| 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.<br><br>**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. |

**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

Save Print



CORPORATE SERVICES NETWORK

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# Claim form

## 1. POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

Policy #

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

Family name Date of birth

Residential address

Suburb State Choose your State Postcode

Postal address

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

Daytime contact number Alternative number

## 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 & INJURY

Date of accident Time AM ☐ PM ☐

Address where accident occurred

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

Witness name(s)

Witness address

Please describe how the accident/injury occurred:

What were the injuries suffered?

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

If yes, please give details:

Provide details of any previous claim made for any previous injury against any insurance company:
(Please attach separate sheet if insufficient space)

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

If yes, please state types and quantities:

## 4. TREATMENT RECEIVED

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 first obtain treatment? 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

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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 |
|---|---|---|---|
| | | | |
| | | | |

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

| Doctors name | Address | Telephone number |
|---|---|---|
| | | |

## 5. NON-MEDICARE MEDICAL EXPENSES

The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap or the Medicare out of pocket amount, and do not attach accounts paid or part paid by Medicare).

Are you a member of an ambulance service? Yes ☐ No ☐

If yes, please give details:

Are you a member of a private health fund? Yes ☐ No ☐

If yes, please give details:

Does your private health insurance have hospital cover? Yes ☐ No ☐

Does your private health insurance cover extras (physio etc.)? Yes ☐ No ☐

| Name of provider | Service (e.g. physio) | Date of service | Charged amount | Private health rebate | Amount claimable AU$ |
|---|---|---|---|---|---|
| | | | $ | $ | $ |
| | | | $ | $ | $ |
| | | | $ | $ | $ |
| | | | $ | $ | $ |
| | | | $ | $ | $ |
| | | | $ | $ | $ |
| | | | | **Total** | $ 0.00 |
| | | | | **Less excess** | $ |
| | | | | **Total amount of claim** | $ 0.00 |

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## 6. ORGANISATION DECLARATION

Organisation name

Organisation official's name

Organisation official's position

Address

Suburb | State Choose your State | Postcode

Daytime contact number | Email (important)

I, the above mentioned Organisation Official, confirm that

(Member's name)
was a Voluntary worker for the organisation and was an insured person as identified in the Personal Accident Insurance with Liberty at the time of the accident. The information contained in this statement is true and correct,
and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Are there any comments in relation to this claim? Yes ☐ No ☐

If yes, please give details:

Signature of official | Date

## 7. 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 (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<br>(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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## 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 average gross weekly salary (as defined by the policy wording) averaged over the previous 12 months 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

## 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

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Name of hospital

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

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 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 ☐

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

Save Print