Claim form

Group Personal Accident & Sickness

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 Proclaim Management Solutions (Proclaim), 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 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.

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 Proclaim on 1300 552 446 or +61 3 9660 5200.

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Liberty
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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 Proclaim 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:

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 understand that by investigating my claim or by accepting proof of my claim, neither Proclaim Management Solutions (Proclaim) or Liberty have accepted liability, nor waived any of their rights in respect of any claim arising under the policy.

I consent to Proclaim 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 Proclaim's Privacy Officer.

I authorise any person or entity to provide to Proclaim or Liberty such personal information (including health information) as Proclaim 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 Proclaim 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, Proclaim or Liberty may not be able to process or assess my claim.

I appoint Proclaim 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.

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 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

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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

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Privacy Notice

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Liberty and Proclaim Management Solution (**Proclaim**) 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 Proclaim.

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.

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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 Proclaim's Data Protection Officer: privacy.officer.ap@libertymutual.com.

If you require a physical mailing address, please contact the Privacy Officer via email: GDPR.enquiries@dwf.law (please mark the subject heading of your email "For the attention of the Data Protection Officer")

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

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