JUA Underwriting Agency Pty Limited

ACN 004 566 465
ABN 70 004 566 465
AFSL 235411

CLAIM No.:

MULTIPLE DISTRICT 201 of LIONS CLUBS INTERNATIONAL Inc.

PERSONAL ACCIDENT CLAIM FORM

UNDERWRITER: LLOYDS, 1 Lime Street, LONDON. EC3M 7HA

Instructions to Club when completing Claim Form>

1. Please refer to the Insurance Summary in the Multiple District Directory for details of the coverage provided under this policy.
2. Please remember that a period of Disablement of less than five (5) days will not be paid. (This is called a Franchise.)
3. In the case of a serious accident, please notify Lion Garry Galvin immediately by telephone or email.
4. Please report any Claim immediately as any late notification could prejudice its outcome and could be an embarrassment to all parties.
5. Additional Benefits cover is for the amount not recoverable from any Private Health Fund and is subject to the provisions of the National Health Act.
6. **Completed Claim Form is to be returned to:**

Lion Garry Galvin
LIONS Australia Insurance Programme Consultant
Authorised Representative – AFSL 001239538
PO Box 6003, KINCUMBER NSW 2251
Phone: (02) 4369 8317 Mobile: 0408 674 770
Email: insurance@lions.org.au

INSURED PERSON'S STATEMENT

Name: _____Date of Birth:_____

Address:_____

_____Postcode:_____

Occupation:_____Phone: (W)_____(H)_____

Email:_____

Lions Club of _____District:_____

Position in Club:_____

Date of Accident:_____Time of Accident:_____

Function at which accident occurred:_____

How did accident occur?_____

_____

_____

Were you engaged in performing duties at the time of the accident: YES / NO

Witnesses: _____

_____

Name, Address & Phone Number of Attending Doctor:_____

_____

Are you in receipt of an Income from your Work? YES / NO If YES:

What is your Gross Weekly Wage? $_____Are you Self-Employed: YES / NO

PLEASE ATTACH A STATEMENT FROM YOUR EMPLOYER SHOEWING YOUR GROSS WEEKLY EARNINGS IMMEDIATELKY PRIOR TO YOUR INJURY. ALTERNATIVELY, ATTACH A COPY OF YOUR LATEST TAXATION ASSESSMENT NOTICE FROM THE AUSTRALIAN TAX OFFICE.

I warrant the truth of the foregoing statement and particulars in every respect and that I have not withheld from the Company any material information in connection with this Claim.

SIGNATURE of INJURED PERSON:_____

DATE:_____

PLEASE HAVE YOUR MEDICAL ATTENDANT COMPLETE THE MEDICAL CERTIFICATE on the next page.

MEDICAL CERTIFICATE

Name of Injured Person: _____

Nature of Injury: (Please provide sufficient particulars of symptoms to enable a Medical Officer of the Company to comment should the Company wish to consult him/her.)

_____

_____

Is the injury consistent with the cause stated above? _____

Please state the date that you consider incapacity from the injury commenced: _____

Have you treated the Injured Person previously for this complaint? If so, please provide full details:

_____

_____

If the Injured Person is suffering from any Disease, irrespective of the present injury, or if there any circumstances which may tend to delay recovery, please give full details:

_____

_____

When did the Injured Person first consult you in connection with this injury? _____

_____

Are you the Injured Person's usual Medical Attendant? YES / NO. If YES, for how long have you known him/her?

_____

<u>TEMPORARY TOTAL DISABILITY:</u> The complete inability of the Injured Person, because of this injury, to perform each and every duty pertaining to his/her regular business or occupation.

If, in your opinion, the Injured Person has been totally disabled as defined above please quote duration:

TOTAL DISABLEMENT: From: _____TO: _____

Expected duration of Injured Person's Total Disablement? _____

I CERTIFY that, to the best of my knowledge, the foregoing statements are correct:

SIGNATURE:_____QUALIFICATION: _____

ADDRESS:_____

PHONE No:_____DATE:_____

AUTHORITY

I hereby authorise any Hospital, Physician or Other Person who has attended me, or any Employer, to furnish JUA UNDERWRITING AGENCY PTY LTD, or its Representatives, any and all information in respect of any Sickness or Injury, Medical History, Consultation, Prescriptions, or Treatment, copies of all Hospital or Medical Records and copies of Records of Employers.

I also agree that a Photocopy of this Authorisation shall be considered as effective and valid as the Original Document.

SIGNATURE OF INJURED PERSON:_____

DATE:_____

LIONS CLUB OFFICIAL CERTIFICATION

I certify that _____

(*Please delete the clause/s below which do not apply)*

- **Is a Member of this Lions/ Lioness/ Leos Club in good standing**
- **Was a Voluntary Worker for this Lions/ Lioness/Leos Club**
- **Is an Accompanying Partner of a member of this Lions/ Lioness/Leos Club**

and was injured in the circumstances described elsewhere in this Claim Form and is, in my opinion, entitled to Benefits under the Lions Personal Accident Policy.

SIGNATURE OF CLUB OFFICER: _____

DATE: _____POSITION IN CLUB:_____

PHONE: _____Email: _____

LIONS/ LIONESS/ LEOS CLUB OF _____

CLUB ADDRESS: _____

_____

HAVE YOU ENCLOSED:

1. **If claiming Weekly Benefits, your Statement of Income?**
2. **If claiming Additional Expenses, all receipts?**

To facilitate prompt settlement of this claim, please provide:

Bank BSB: _____ACCOUNT NO.:_____

In the name of: _____