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

Instructions to Club when completing this 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 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 the ***Lions Insurance Program Consultant*** 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 Medicare and/or any Private Health Fund and is subject to the provisions of the Health Act.
6. **Please note that, under the Health Act 1953, General Insurers are prohibited from reimbursing any medical gap shortfall.**
7. **Please ensure that your Lions Club Certification on final page is completed prior to submission of your Claim.**
8. **Completed Claim Form is to be returned to:**

PDG R.N. (Bob) Korotcoff OAM Dip Fin Serv.
LIONS Australia Insurance Program Consultant
Authorised Representative – AFSL 000278958 of JUA Underwriting Agency Pty Ltd
14 Dover Court, DOVER GARDENS SA 5048
Telephone: 0418 831 426
Email: insurance@lions.org.au
Website: www.lionsclubs.org.au/insurance

Policy underwritten by certain Underwriters at Lloyd's of London under Authority held by
JUA Underwriting Agency Pty Ltd ABN 70 004 566 465

IMPORTANT INFORMATION

Please complete ALL questions and send this form to the Lions Insurance Program Consultant to enable prompt processing of your Claim. If there is insufficient space on this form to provide your answers, please attach a separate paper.

Your Claim cannot be processed until:

- You have fully completed the Claim Form, signed the Declaration and provided any supporting documentation that may be required;
- We receive Medical Statements about your condition if they are required;

JUA Underwriting Agency Pty Ltd (JUA) subscribes to the General Insurance Code of Practice that sets the standards of practice and service for the Insurance Industry. It is our aim to provide a quality service to you, our customer. In the event that we don't achieve our aim and cannot resolve the matter with you, we have a dispute resolution process that you can access. Full details appear in the policy document under Code of Practice.

PRIVACY STATEMENT

Lloyd's and its Agents are bound by the obligations of the Privacy Act 1988 as amended by the Privacy Amendment (Private Sector) Act 2000 (the Act). This sets out basic standards relating to the collection, use, disclosure and handling of personal information.

"Personal Information" is essentially information or an opinion about a living individual whose identity is apparent, or can be reasonably ascertained, from the information or opinion.

Information will be obtained from individuals directly where possible. Sometimes it may be collected indirectly (e.g. from your representatives).

Only information necessary for this arrangement and administration of Lloyd's business by Lloyd's, its agents and their representatives will be collected. This includes information necessary to accept the risk, to assess the claim, to determine competitive and appropriate premiums etc.

Lloyd's and its agents disclose personal information to third parties who they believe are necessary to assist them in doing the above. These parties will only use the personal information for the purposes we provided it to them for (or if required by law).

When you give Lloyd's or their agents personal information about other individuals, we rely on you to have made or make them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, and the relevant purposes we, and the third parties we disclose it to, will use it for and how they can access it. If it is sensitive information, we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.

You are entitled to access your information, if you wish, and request correction if required. You may also opt out of receiving materials sent by Lloyd's by contacting:

JUA Underwriting Agency Pty Ltd on (02) 8272 4800.

COMPLETING YOUR CLAIM FORM

We wish to ensure that your Claim is processed promptly.

To assist us, please use this Check List.

- ☐ Have you answered ALL questions for your section of the Claim Form?
- ☐ Have you **signed and dated** the Claim Form?
- ☐ Has the Statement by your usual Doctor been completed and signed?
- ☐ If your treating Doctor is different to your usual Doctor, has the Statement by the treating Doctor been completed and signed? If not, have you obtained and supplied copies of reports provided to your usual Doctor?
- ☐ Have you attached the Employer/Principal Contractor Declaration?
- ☐ Have you provided copies of Payslips for the period you are receiving Benefits?

If your disablement is ongoing, a medical certificate **must** be provided every **FOUR WEEKS.**

The certificate must be mailed or emailed to us to make sure that benefit payments are not delayed.

The medical certificate must state the REASON for your disablement. For example, the words "Medical Condition" cannot be accepted.

If you assist us, we will ensure that:

- You will be notified as soon as your claim has been received.
- Once all the paperwork is received an assessment of your claim will be provided within 5 working days.
- Upon acceptance of your claim, Benefit payments are made 2 weeks in arrears thereafter.

PLEASE NOTE: All Benefit Payments are made gross. That is, no income/PAYG tax is deducted from these payments. It is your responsibility to report this when declaring your Annual Tax Return.

PLEASE RETURN YOUR CLAIM FORM (& ongoing Medical Certificates, if applicable) to:

PDG R.N. (Bob) Korotcoff OAM Dip Fin Serv.
LIONS Australia Insurance Program Consultant
Authorised Representative – AFSL 000278958
of JUA Underwriting Agency Pty Ltd
14 Dover Court, DOVER GARDENS SA 5048
Telephone: 0418 831 426
Email: insurance@lions.org.au

SECTION A – PERSONAL DETAILS

Claimant's Surname		Given Name(s)			
Home Address					
Suburb		State		Postcode	
Email					
Date of Birth		Height	cm	Weight	kg
Employer					
Occupation		Are you in Permanent Employment?		YES / NO	
Payroll/ID Number					

CLAIM PAYMENTS	Upon acceptance of your claim, benefit payments will be paid direct into your Account (unless advised otherwise). Please provide your Financial Institution details as follows:		
Bank Name			
Account Number		BSB	
Account Holder Name(s)			

STATEMENT OF CLAIM

Date of Your Accident		Time of Accident		AM or PM (circle)
Full details of the Accident and injuries sustained				
First day you were unable to work		Date returned to work (OR expected date)		
Name of Witness (if any) to the Accident				
Event at which accident occurred				

How did accident occur?	

Were you engaged in performing duties on behalf of Lions at the time of the accident?	YES / NO

Witness Details:

1. **Name:** ____

   Address: ____

   Phone: ____________________ **Email:** ____________________________

2. **Name:** ____

   Address: ____

   Phone: ____________________ **Email:** ____________________________

PHYSICIAN DETAILS

Details of your usual Doctor	Name:		Phone Number		
Address					
Suburb		State		Postcode	
Details of first doctor consulted	Name:		Date Treated		
Address				Postcode	
Details of any other attending physicians and/or hospitals					
Name		Date Treated			
Name		Date Treated			
Name		Date Treated			
Details of future treatment (e.g. Surgery, Physiotherapy etc.)					

MEDICAL AND CLAIMS HISTORY			
Are you making or entitled to make a claim under:			
Workers' Compensation	Yes ☐ No ☐	Motor Vehicle Accident	Yes ☐ No ☐
Other Government Benefits	Yes ☐ No ☐	Other (e.g. Annual Leave or Sick Pay)	Yes ☐ No ☐
If "Yes" to any of the above, please provide full details.			
What (if any) other claims have you ever made under an Accident & Sickness Insurance Policy?			
Are you insured elsewhere under an Accident & Sickness Insurance Policy?			
If Yes, please provide full details			
Have you engaged in any other Income Earning employment since becoming disabled?			
If Yes, please provide full details	Employer Name:		
Are you Self-Employed?	Yes ☐ No ☐	Gross Weekly Wage	$

Please attach a statement from your Employer showing your Gross Weekly Earnings 52 weeks prior to your injury. Alternatively, attach a copy of your latest Taxation Assessment Notice from the Australian Tax Office.

DECLARATIONS & MEDICAL AUTHORISATIONS

- I solemnly and sincerely DECLARE that the information given by me in this Claim is true and complete.
- I AGREE to supply any further information that may be requested of me in connection with my Claim.
- I AUTHORISE any Doctor, Dentist, Physiotherapist, Company, Firm or person to disclose to JUA Underwriting Agency Pty Ltd (JUA) any and all information that they may request in connection with this claim.
- I AGREE that a photocopy of this Authorisation shall be considered to be effective and valid as the original.
- I have read and accept the Privacy Statement provided with this Claim Form.

___________________________________ ______________________

Signature **Date**

Print Name _______________________________________

SECTION B – DOCTOR'S STATEMENT

The Patient is responsible for any fee charged to complete this Statement	
Claimant's Name:	
How long has the claimant been your patient or a patient of this Practice?	
What date were you first consulted by the patient in connection with the present Injury?	
How long has the patient been experiencing symptoms before consulting you for the first time?	
Please describe the exact nature of the Injury	
Please advise the circumstances surrounding the accident, if made aware.	
Is the current condition in any way related to the patient's work?	
If "Yes", would you support a Workers' Compensation Claim?	
Please provide details of all treatment and/or hospitalisation	
Please enclose results of any tests performed	
Details of all proposed treatment	
Has the patient previously suffered from the same or similar condition?	Yes ☐ No ☐
If "Yes", please provide full details including dates of consultations	
Is there anything in the patient's history which may have contributed, directly or indirectly, to the Injury?	Yes ☐ No ☐
If "Yes", please provide full details	

Have you referred the patient for other services and/or specialist treatment?	Yes ☐ No ☐
If "Yes", please provide full details	
Is the patient suffering from any Disease, irrespective of the present injury, or are there any circumstances which may tend to delay recovery? If so, please provide details.	
Has the patient continued to follow medical advice?	Yes ☐ No ☐
When was the patient obliged to cease work?	
When do you expect the patient to be able to resume work?	
If able to resume work in a reduced capacity, when would you expect this to be?	
TEMPORARY TOTAL DISABLEMENT: 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 Peerson has been totally disabled as defined above, please quote duration: TOTAL DISABLEMENT: From ___________________________ To __________________________	
Additional Remarks and prognosis:	

Doctor's Contact Details	Name:		
Address:			
Phone:		Fax Number	
Email			

I hereby certify that I have personally examined the abovenamed claimant and that in my opinion the statements made in the **Statement of Claim** section of this Claim Form are consistent with the Claimant's injury. I have read and accept the Privacy Statement provided with this Claim Form.

Signature: _______________________________________ Date __________________________

Qualifications: ____

Thank you for your assistance

LIONS CLUB OFFICIAL CERTIFICATION

I certify that ____

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

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

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

SIGNATURE OF CLUB OFFICER: ____

DATE: ________________________ POSITION IN CLUB: _______________________________

LIONS/LEOS CLUB OF ____

CLUB ADDRESS: ____

CLUB EMAIL ADDRESS: ____

CONTACT PHONE NUMBER: ____