

# Personal Injury

## Claim Form

### Important Information

Please download/save this Claim Form to enter your claim details.

To assist us to consider your claim as soon as possible please complete ALL questions in full.

1. Please complete the Policy Details Section and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully.
3. To avoid delay in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
4. Claims may be subject to an excess as described in your Policy.
5. Please click the submit button to email this form to Chubb and attach any applicable documentation required.
6. We now accept digital signatures on this form, please click in the signature field to add your signature.

It is important you provide honest, complete, up-to-date and relevant information when completing this form.

### Section 1: Policy and Claimant Details

Policyholder - Claimant <input type="checkbox"/> Other <input type="checkbox"/>	Given Name	Mr/Mrs/Miss/Ms				
Policy/Certificate Number					Expiry Date	
Name of Broker who provided the cover						
Surname				First Names		
Home Address					State	Postcode
Postal Address	(if different from above)				State	Postcode
Phone Numbers:	Private		Business		Mobile	
Email Address						
Employer's Name						
Occupation						
Usual Duties					Date of Birth	
What are your gross weekly earnings? \$						
Who are you claiming for?	Self <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/>	Spouse/Partner <input type="checkbox"/>	Given name		
What are you claiming for? (e.g. Temporary Total Disablement)						

## Electronic Funds Transfer Details

Following Chubb approval of your claim, should you wish to have your claim benefits transferred directly into your bank account, please provide the following details:

### Australian Bank Account Details

Name of Financial Institution		Account Holder's Name	
BSB Number		Account Number	

### GST Information (For Australian Claims Only)

a) Are you registered for GST Purposes?	<input type="checkbox"/> Yes <input type="checkbox"/> No
b) What is your Australian Business Number (ABN)?	
c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) in respect to the GST paid on the insurance policy under which this claim is being made?	<input type="checkbox"/> Yes <input type="checkbox"/> No
d) If Yes, what percentage of the GST did you claim or are you entitled to claim? (if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)	%

## Section 2 - Claims for Injury/Illness/Death

What is the injury or illness?

If injury, how exactly did it occur?

i.e. playing sport, etc.

When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed?		
Did the injury or illness cause you to stop work?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, when?
Have you returned to work full-time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, when?
Have you returned to work part-time?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, when?

If Yes, - what hours and duties are you working?

Days		Hours		Duties	
Is this condition due to injury or sickness arising out of your employment?					<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, give details	
If Injury, how exactly did it occur?	

Who is your usual family doctor?

Name	
Address	
Telephone Numbers	
When did you first get treatment from a medical practitioner for this condition?	
Doctor's Name	
Address	
Telephone Number	

Have you consulted any other medical practitioner for this condition? If Yes, give details				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Doctor's Name					
Address					
Telephone Number				Period	
Did you go to hospital? If Yes, give details				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Hospital Name					
Address					
Dates of Admission and Discharge		Admission		Discharge	
Number of Days in Hospital					
During the 24 hours before the injury, did you drink any alcohol or take any drugs? If Yes, give details				<input type="checkbox"/> Yes <input type="checkbox"/> No	
State types & quantities					
Have you ever had this or a similar condition in the past? If Yes, give details				<input type="checkbox"/> Yes <input type="checkbox"/> No	
Date(s),					
Treatment received					
Name of treating Doctors/Specialists					
Addresses of Doctors/Specialist who treated you					
What other significant medical or surgical treatment have you received in the past 5 years? Please give details below					
Date(s)					
Nature of the condition(s) treated					
Name of treating Doctors/Specialists					
Addresses of Doctors/Specialist who treated you					
Are you affected by any other long term or chronic disability? If Yes, give details				<input type="checkbox"/> Yes <input type="checkbox"/> No	

### Section 3 - Claims for additional Benefits for Injury or Illness

Not all Policies provide these Benefits. Please only complete if applicable

Are you claiming for:

- homecare or income replacement after major surgery for cancer
- childminding or income replacement after a child's accident
- home tuition fees after a child's accident
- medical expenses not covered by Medicare
- damage to personal property

Give details, specifying each item

Item	Amount
	A\$
	A\$
	A\$
	A\$

Please attach invoices or other evidence of the expenses you have incurred or receipts for damaged property.

#### Section 4 - Other Insurance/Benefits

Are you claiming insurance or compensation from any other insurance company?

eg. Workers Compensation, Traffic Accident Commission, sports body or any income replacement. If Yes, give details below

☐ Yes ☐ No

Name of insured organisation/employer & telephone number

Name of Insurer		Telephone No.	
Type of cover		Amount claimed per week	
Do you have private health insurance?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, give details	
Do you have ambulance cover?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If Yes, give details	

#### Section 5 - To be Completed by Your Employer

If Self Employed please provide your Tax Assessment advice from the ATO from the previous financial year as proof of your earnings.

Name of Employer			
This is to certify that		of	
has been unable to attend his/her occupation as a result of Injury or Sickness from		to	
His/Her average Gross Weekly Salary at the time of this accident/sickness was	A\$		per week
He/She has been employed since			
His/Her Sick Leave Entitlement at the time of this accident/sickness was	days		
Has a claim for Worker's Compensation been lodged	<input type="checkbox"/> Yes <input type="checkbox"/> No		
In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature of Employer or Supervisor			
Name of Employer or Supervisor (please print)			
Telephone Number		Date	

## Chubb Insurance Australia Limited, Claim Privacy Consent and Declaration

### Claim Privacy Consent

Chubb Insurance Australia Limited (Chubb) collects, uses and handles your personal information in accordance with the Privacy Act 1988 (Cth). You can access a copy of our Privacy Policy on our website at <https://www2.chubb.com/au-en/footer/privacy.aspx> or by contacting our customer relations team.

Your personal information will be used by Chubb, or third parties engaged by Chubb, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes including customer surveys.

In so far as it is relevant to the claim, your personal information may include:

- a) information that is health information or sensitive information, including, without limitation, your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your health insurance claims history, including Medicare;
- b) information relating to other insurance policies, including terms and conditions and claims history;
- c) details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time);
- d) information relating to your income, assets, liabilities and solvency;
- e) information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit;
- f) payment or billing information, such as bank account details, direct debit and credit card details or premium funding and insurance payment arrangements; and
- g) any other personal information that you may provide to Chubb or its third party contractors.

### Collection from and Disclosure to Third Parties

To assess and process your claim Chubb may need to collect your personal information from third parties such as, but not limited to, your insurance broker, claims reference services, government organisations (for example, social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant or investigator retained by Chubb, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate.

Chubb may disclose your personal information, including health and sensitive information, to other entities within the Chubb Group, other insurers, our reinsurers or third parties, including contractors and contracted service providers (such as assessors or investigators) who we, or those other Chubb Group entities, have engaged to provide a specific service related to the administration of your claim and the policy. Those entities may be located overseas, for example the regional head offices of Chubb in Singapore, UK or USA or third parties with whom we or those other Chubb Group entities have subcontracted to provide a specific service for us, which may be located outside of Australia (such as in the Philippines or USA). These entities and their locations may change from time to time. Please contact us, if you would like a full list of the countries in which these third parties are located.

Chubb may also disclose your personal information to witnesses in respect to your claim and to government agencies including the police (where we are compelled to by law).

If you'd like a copy of your personal information or wish to correct or update it, want to withdraw your consent to receiving offers of products of services from us or persons we have an association with, please complete Our Personal Information Request Form online or download it from [www2.chubb.com/au-en/footer/privacy.aspx](https://www2.chubb.com/au-en/footer/privacy.aspx) and return to CustomerService.AUNZ@chubb.com or contact our customer relations team on 1800 815 675.

Please note if you do not consent to the terms of this Privacy Consent or revoke your consent, Chubb may not be able to process or assess your claim.

### Privacy Consent, Declaration and Authority

I:

- consent to the collection, use and disclosure of my personal information in accordance with Chubb's Privacy Policy and this document for the assessment of my claim. This consent remains valid unless I alter or revoke it by giving written notice to Chubb as outlined above;
- understand that by investigating my claim or by accepting proof of my claim, Chubb has made no acceptance of liability, nor waived any of its rights in defense of any claim arising under the insurance policy;
- agree to use my best endeavors and render all reasonable assistance and co-operation to Chubb in the assessment of my claim;
- confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim;
- understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- authorise any person or entity, including but not limited to the third parties referred to above, to provide to Chubb such personal information as Chubb considers relevant for its assessment of my claim;
- authorise Chubb to disclose my personal information (including sensitive/health information) to other third parties referred to above (who may be located overseas) where relevant to the assessment of my claim;
- appoint Chubb to do everything necessary including to execute on my behalf any documents or do such acts as required to give effect to this Privacy Consent, Declaration and Authority.

Signature of Claimant			
Name of Claimant		Date	

## Section 7 - Medical Practitioner's Statement to Company

The Policyholder is responsible for any fee for this statement.  
This form should be completed and returned to Chubb promptly.

Patient's Full Name					
Height	cms	Weight	kgs	Date of Birth	
Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound)					
Cause:					
If available please provide a copy of X-ray report					
Is this condition an injury <input type="checkbox"/> or an illness <input type="checkbox"/>					
Does the patient have any other injury or illness that is contributing to the condition? eg: Osteoporosis					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, give details					
Is condition due to injury or sickness arising out of the patient's employment?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, give details					
Was the disability sports related?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, give details					
Date of onset/first symptoms?					
When did the patient first consult you for this condition?					
Has the patient ever had the same or similar condition?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, give details					
How long have you been the patient's usual doctor/medical practice?			years		
Has the patient been hospitalised?	Date of Admission		Date of Discharge		
Name of Hospital					
Name of patient's usual doctor/medical practice					
Has the patient had surgery or is it anticipated?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, give details					
Date performed or anticipated			Name of hospital		
Did you provide other medical services (including pathology) to the patient?					<input type="checkbox"/> Yes <input type="checkbox"/> No
If Yes, itemise, date, give details					
Was the patient referred by you or to you?					<input type="checkbox"/> Yes <input type="checkbox"/> No
Please provide:					
Name of referring doctor					
Address of referring doctor					
Date of referral					

## Section 7 - Medical Practitioner's Statement to Company (Continued)

Is the patient still disabled?	<input type="checkbox"/> No	when did the patient return to work?			
	<input type="checkbox"/> 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

If partially disabled, what duties could the patient perform and for how many hours a week?

		Hours per week
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?		<input type="checkbox"/> Yes <input type="checkbox"/> No

If Yes, give details:

Name of Company and Claim No.	
Contact Name and Telephone No.	

Remarks:

Signature of medical practitioner			
Name - print		Date	
Qualifications			
Address			
Telephone Number			

## To Be Completed by the Insured for all Claims on Group Personal Injury and/or Sickness Policies

I,			
confirm that			
is an Employee/Member/Volunteer Worker/Other (Please Specify)			
of (company name)			
and that he/she is eligible to claim for the Injury/Illness occurring on			
Signature		Name	
Title		Contact Number	
Claim Reference (if known)			
Policy Number (if known)			

Please click to submit your claim form

## About Chubb in Australia

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Chubb is the world's largest publicly traded property and casualty insurer. With operations in 54 countries and territories, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients. As an underwriting company, we assess, assume and manage risk with insight and discipline. We service and pay our claims fairly and promptly. The company is also defined by its extensive product and service offerings, broad distribution capabilities, exceptional financial strength and local operations globally. Parent company Chubb Limited is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index. Chubb maintains executive offices in Zurich, New York, London, Paris and other locations, and employs more than 30,000 people worldwide.

Chubb, via acquisitions by its predecessor companies, has been present in Australia for 100 years. Its operation in Australia (Chubb Insurance Australia Limited) provides specialised and customised coverages, including Business Package, Marine, Property, Liability, Energy, Professional Indemnity, Directors & Officers, Financial Lines, Utilities, as well as Accident & Health insurance, to a broad client base, including many of the country's largest companies. Chubb also serves successful individuals with substantial assets to protect and individuals purchasing travel and personal accident insurance. With five branches and more than 800 staff in Australia, it has a wealth of local expertise backed by its global reach and breadth of resources.

More information can be found at [www.chubb.com/au](http://www.chubb.com/au).

## Contact Us

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