ACCIDENT AND ILLNESS
CLAIM FORM & INITIAL MEDICAL CERTIFICATE

NOTES

1. It is MOST IMPORTANT that ALL QUESTIONS ARE ANSWERED where necessary. This will greatly assist us to process your claim as quickly as possible.
2. The issue of this claim form is not an admission of liability by QBE.
3. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.

JURISDICTION
Except to the extent otherwise provided in any subsequently issued policy, the content and use of this form and any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by the laws of New Zealand and in relation to those matters, the parties submit to the jurisdiction of the Courts of New Zealand.

DRIVER DETAILS

Policy No.					
Insured's name					
Insured Person's name		Date of Birth	/ /		
Address					
Daytime telephone	(0)	Fax	(0)	Business telephone	(0)
E-mail					
Occupation					
Brief description of all the duties of your usual occupation					
To whom is the benefitpayable					

If the claim is a result of an ACCIDENT, please complete Part 1.
If the claim is a result of an ILLNESS, please complete Part 2.

PART 1. PARTICULARS OF ACCIDENT

Exact locationof accident					
Date of accident/incident	/ /	Time		am	pm
What were you doing at the time of the accident?					
How did the accident occur?					

Did the accident occur during the course of your occupation? Yes No

What injuries have you sustained?			

Please give the names and addresses of any witnesses who saw the accident

(1)	Name		Relationship	
	Address			
(2)	Name		Relationship	
	Address			

PART 2. PARTICULARS OF ILLNESS

Date of first symptoms

Nature of illness

PLEASE COMPLETE THE FOLLOWING FOR ALL CLAIMS.

OTHER INFORMATION

In respect of this new claim:

On which date did you first consult a doctor? / /

On which date did you cease work entirely as a result of this accident or illness? / /

Have you resumed work since? Yes ☐ No ☐

If Yes, on which date did you resume work? / /

If No, when do you expect to resume work? / /

Immediately prior to the accident or illness were you in good health and free from disability? Yes ☐ No ☐

If No, what was your state of health or what disability were you suffering from?

Names and address of all doctors who attended to you during this accident or illness

(1) Name

Address

(2) Name

Address

Name of your usual doctor

Address

Were you hospitalised overnight for this accident or illness? Yes ☐ No ☐

If Yes, please give name of the hospital and the duration of your stay

Did you require an operation for this accident or illness? Yes ☐ No ☐

If Yes, please give details of the nature of the operation and the name of the surgeon who conducted the operation.

Are you engaged in any other occupation whilst prevented by your accident or illness from attending to your usual occupation? Yes ☐ No ☐

Are you entirely prevented from attending to your usual occupation by this accident or illness? Yes ☐ No ☐

If No, please give details as to what you can do

Are you able to carry out any part of your usual or other occupation? Yes ☐ No ☐

If Yes, please advise:

(a) what duties are you able to carry out?

and (b) what proportion of your usual income can you continue to earn from these duties?

Will you continue to earn any income from any other source while you are disabled? Yes ☐ No ☐

If Yes, please advise how much and from what source

Do you have any other insurances under which a claim could be made? Yes ☐ No ☐

If Yes, please provide details of name of Insurer, Policy Number and Type of Policy

Insurer

Policy number Type of policy

Will you be receiving weekly compensation from ACC? Yes ☐ No ☐

If Yes, (a) Advise at which office of ACC, and the reference number if known

(b) What will be the amount paid each week? $

If you are self employed, what was your gross income from any source (after deduction of all operating expenses of your business or practice) for:

(a) the 12 months prior to the last 31 March? $

and (b) the 12 months immediately prior to the date of your disablement? $

If you are not self employed, what was your gross basic salary and income from any other source (excluding bonuses, commission, overtime payments and other allowances) for:

(a) the 12 months prior to the last 31 March? $

and (b) the 12 months immediately prior to the date of your disablement? $

Have you ever previously met with a similar accident or have you ever suffered from a similar illness? Yes ☐ No ☐

If Yes, please give full details (date, duration etc.)

PLEASE FORWARD THIS CLAIM FORM AND INITIAL CLAIMS MEDICAL CERTIFICATE TO US IMMEDIATELY.

IMPORTANT NOTICE

Your policy may contain a condition that if you receive any weekly compensation from Accident Rehabilitation and Compensation Insurance Corporation, then the amount of any such weekly compensation shall be deducted from any weekly or monthly benefits payable under this policy for the same period.

In consideration of QBE commencing the payment of benefits under this policy before the final determination of any weekly compensation from Accident Rehabilitation and Compensation Insurance Corporation I agree to refund to QBE any amount overpaid by QBE as a result of the delay in determining the amount of such weekly compensation.

Insured/s Signature(s)		Date	/ /
Address			

DECLARATION

I/We declare that:

(a) The information and answers given above are correct to the best of our/my knowledge and belief. I/We have not withheld any information likely to affect QBE's consideration of the claim;

(b) I/We understand that QBE requires this information (which will be retained by QBE) to evaluate the claim. I/We understand that the Privacy Act 1993 entitles me/us to have access to and request the correction of the information;

(c) QBE is authorised to disclose information contained herein to QBE's advisors, reinsurers and to other insurers. I/We authorise QBE to obtain, from any other party, information that is, in QBE's view relevant to this claim.

Insured/s Signature(s)		Date	/ /

INITIAL CLAIMS
MEDICAL CERTIFICATE

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THIS CERTIFICATE IS TO BE COMPLETED BY THE MEDICAL ATTENDANT OF AND AT THE EXPENSE OF THE INSURED PERSON

Full name of Insured person

Occupation

Are you the Insured Person's usual Medical Attendant Yes ☐ No ☐

IF THE CLAIM IS A RESULT OF AN ACCIDENT, PLEASE COMPLETE THIS SECTION

Details of Accident as advised by the Insured Person

Accident occurred at

On the ☐ day of ☐ 200 ☐ at ☐ am ☐ pm ☐

Circumstances of Accident as advised by Insured Person

Nature and extent of injuries

Are the injuries consistent with circumstances of the Accident? Yes ☐ No ☐

If NO, please give details

Are you aware if the Insured Person has ever suffered similar injuries before? Yes ☐ No ☐

If YES, please give details

IF THE CLAIM IS A RESULT OF AN ILLNESS, PLEASE COMPLETE THIS SECTION

What is the exact nature of the Illness?

When did symptoms first become apparent?

Has the Insured Person ever suffered from the same or similar Illness before? Yes ☐ No ☐

If YES, please give details

Is there a likelihood of a recurrence of this Illness?

PLEASE COMPLETE THIS SECTION FOR ALL CLAIMS

On what date did the Insured Person first seek medical advice? / /

On what date was the Insured Person first incapacitated by this accident or illness? / /

Did this incapacity prevent the Insured Person from attending to all duties of his/her usual occupation? Yes ☐ No ☐

Please tick any of the following activities in which the Insured Person is restricted by his/her disability:

☐ Standing	☐ Walking	☐ Sitting	☐ Stretching up or across
☐ Repetitive movements	☐ Bending	☐ Squatting or crouching	☐ Twisting body or neck
☐ Heavy lifting, pulling or carrying	☐ Using hand tools	☐ Driving	☐ Mental activities
☐ Mood or personality	☐ Other (please specify)		

Indicate maximum hours per day (or week) the Insured Person can work (such as full duties for half days). Describe the limits of tolerances for each of the activities indicated (such as 5 minute breaks every hour for repetitive movements).

Has the Insured Person returned to his/her usual occupation? Yes ☐ No ☐

If YES, please advise what date / /

If NO, what is the estimated date of return to the usual occupation? / /

Will the Insured Person require surgery or hospitalisation before returning to his/her usual occupation? Yes ☐ No ☐

If YES to either, please give details and waiting time

Is there any reason why the Insured Person should not be able to return to his/her usual occupation? Yes ☐ No ☐

If YES, please advise the reason:

I certify that to the best of my belief the foregoing statements are correct

Name

Signature Date / /

Address

Qualifications