# casualty

## *personal accident and illness claim form*

Lumley General

Lumley General Insurance (N.Z.) Limited, Head Office, Lumley Centre, 88 Shortland Street, PO Box 2426, Auckland, New Zealand, Tel 09 308 1100, Fax 09 308 1114

## Insured details **please ensure all questions are answered**

**Name of the Insured person:**

**Address:**

**Daytime phone number:** **Evening phone number:**

**Present occupation:** **Date of birth:** / /

**Name of Insured (if different from above):**

## Accident details

Location:

Time: am/pm Date: / /

What was the insured person doing at the time of the accident?

How was it caused?

What injuries have been sustained?

Name and address of any witnesses:

## Illness details

When first contracted: / /

Nature of illness:

## Further details

**1** Has the Insured Person ever previously met with a similar accident or ever suffered from a similar illness? Yes ☐ No ☐

If **Yes**, please give details (date, duration etc):

**2** What has been the Insured Person's occupation since the policy was issued?

**3** Is the Insured Person insured against accident or illness with any other company or Friendly Society? Yes ☐ No ☐

**4** Is the Insured Person receiving or entitled to receive benefits under the Accident Compensation Act or any sickness benefit? Yes ☐ No ☐

**5** Has the Insured Person been able, since the accident/illness occurred, to attend in any way to any portion of their business? Yes ☐ No ☐

**6** Has the Insured Person been able to engage in any other paid employment? Yes ☐ No ☐

**7** State the extent and duration of their inability to attend to their business or occupation:

Disabled wholly for days, from / / to / /

Disabled partially for days, from / / to / /

I am now (insert "wholly", or "not at all" as the case may be) disabled

If still disabled, state how much longer the disability is likely to continue:

**8** Name and address of the Insured Person's usual medical attendant:

**9** If current medical attendant had been known for less than three years, please state name and address of previous medical attendant:

Any claims must be supported by a report on the reverse side of this form from your medical attendant, and any fee for the report is payable by yourself.
**Please ensure declaration and medical certificate overleaf are completed.**

## Medical report this needs to be completed in every case by your usual doctor

Name of Insured Person:

### Accident

**1** Describe fully the cause and circumstances of the accident as stated by you:

**2** Are the injuries consistent therewith? Yes ☐ No ☐

**3** Do you believe the insured persons injusies were caused as stated? Yes ☐ No ☐

**4** Nature of Injury (please give detailed particulars):

### Illness

**1** Nature of illness:

**2** Date of commencement: / /

**3** Present condition (state as clearly as possible):

### General questions (to be completed for accident or illness)

**1** On what date did the Insured Person first consult you in connection with this accident or illness? / /

**2** (a) Are you the Insured's usual medical attendant? Yes ☐ No ☐

(b) If **Yes**, how long have you known him/her?

**3** (a) Has the Insured Person previously suffered from a similar illness or condition which has affected the present condition in any way? Yes ☐ No ☐

(b) If **Yes**,

(i) When? / /

(ii) Was a full recovery made? Yes ☐ No ☐

(iii) What was the nature of the illness or condition?

**4** Is the Insured Person suffering from any injury or illness irrespective of that stated above? Yes ☐ No ☐

If **So**, please give details and to what extent recovery will be affected:

**5** How long was or will the Insured Person be:

(a) Totally disabled from working? From / / to / / (inclusive)

(b) Partially disabled from working? From / / to / / (inclusive)

General comments:

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

Medical attendants name (Please print): Qualifications:

Address:

Signature: Date: / /

## Pursuant to the Privacy Act

The following is brought to your attention.

(a) This proposal collects personal information about you.

(b) The information is collected to evaluate your claim.

(c) The intended recipient of the information is Lumley General Insurance (N.Z.) Limited.

(d) The information is being collected and held by Lumley General Insurance (N.Z.) Limited of PO Box 2426, Auckland.

(e) The collection of this information is required pursuant to the terms of your Insurance policy.

(f) The failure to provide this information may result in your application for insurance being declined.

(g) You have the rights of access to, and correction of, this information subject to the provisions of the Privacy Act 1993

## Declaration

I/We declare that:

(a) The information given in this form is correct.

(b) I/We hereby claim compensation for Disablement.

(c) The Insured Person was in no way under the influence of intoxicating liquor or drugs when the accident occurred.

(d) The Insured Person will not abstain from his/her usual occupation, for no longer than necessary in consequence of the accident or illness.

(e) The said accident or illness is the sole cause of the Insured Person's Disablement.

(f) I authorise any medical consultants I have consulted to provide medical details that may be requested by Lumley General Insurance (N.Z.) Limited.

(g) I/We authorise the disclosure of personal information held by any other party regarding this claim.

(h) I/We agree to Lumley General Insurance (N.Z.) Limited releasing to other parties personal information regarding this claim.

(i) I authorise Lumley General Insurance to lodge information in relation to this claim on the Insurance Claims Register.

**(Note: Failure to provide full and truthful information could result in the claim being declined.)**

Insured person's signature: Date: / /

Insured's signature (if different): Date: / /