Personal Accident Claim Form - Students

Gallagher Broking Services handle all claims on behalf of the Insurer and the University. Students should lodge the claim and any supporting documentation directly with Gallagher Brokering Services preferably by sending a completed claim form via **email** to claims_GriffithUniversity@ajg.com or alternatively via fax or registered mail to the below address.

Gallagher Broking Services
Level 12, 201 Miller Street, North Sydney NSW 2060
PO Box 6007, North Sydney NSW 2059
Fax: +61 2 9242 2079

Gallagher will review the claim and undertakes the process of managing the claim to finalisation. If further information is required Gallagher will approach the staff member/student directly to obtain such. Resolution of the claim will take place directly between Gallagher and the claimant. Gallagher will immediately report the lodging of any claim to **THE UNIVERSITY** via email before payment of any claim and seek approval to proceed with the payment of the claim.

The **Privacy Consent section** must also be signed for all claims. **For medical claims** – enclose all the relevant documents to support your claim. Medical reports may be necessary therefore the Privacy Consent section on this form must also be signed and completed by you.

This form must be fully completed in the sections applicable to your claim.

Insurer	***Chubb Insurance Company of Australia***		
Policy Number:	***04PO007669***	***Expiry Date 1st November***	
Insured:	***Griffith University***		
Student Name		**Student ID No**	
Address:			
Usual occupation:		**Date of Birth**	
Height		**Weight**	
Telephone (private)		**Telephone (work)**	
Telephone (mobile)		**Email (important)**	
What Are your Gross Weekly Earnings? (Claims for Loss of Wages)			$
For whom are you claiming?	Self / Spouse / Partner / Child. Give Name		
For what are you claiming?	Total Permanent Disablement Temporary Partial Disablement Death		

SUMMARY OF CLAIM:
I am claiming the following benefits under this Insurance.

Death & Capital benefits

Weekly Benefits Period to

Other (Please specify) $

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? Yes / No		**If Yes state when**	
Have you returned to work full-time? Yes / No		**If Yes state when**	
Have you returned to work part-time? Yes / No		**If Yes state when**	

If Yes, what hours and duties are you working?		**If Yes state when**	
Is this condition due to injury or sickness arising out of your employment? Yes /No			
If yes give details			
Who is your usual family doctor?			
Name		**Telephone No**	
Address			
When did you first get treatment from a medical practitioner for this condition?			
Name		**Telephone No**	
Address			
When did you first see the medical practitioner?			
Have you consulted any other medical practitioner for this condition? Yes / No			
Name		**Telephone No**	
Address			
When did you first see the medical practitioner?			
Did you go to hospital? Yes /No			
Hospital Name		**Telephone No**	
Address			
Admission Date	**Discharge Date**		**No of Days**
During the 24 hours before the injury, did you drink any alcohol or take any drugs? Yes/No			
State types & quantities			
Have you ever had this or a similar condition in the past? Yes / No			
Treatment Received			
Treatment Start	**Treatment Completed**		**No of Days**
Doctor's Name		**Telephone No**	
Address			
What other significant medical or surgical treatment have you had in the past 5 years?			
Treatment Received			
Treatment Start	**Treatment Completed**		**No of Days**
Doctor's Name		**Telephone No**	
Address			
Are you affected by any other long term or chronic disability Yes / No			
Provide Details			

CLAIMS FOR ADDITIONAL BENEFITS FOR INJURY OR ILLNESS

Are you claiming for:-
Medical expenses not covered by Medicare
Please advise any further costs e.g. physiotherapy, dental, x-ray

ITEM	**AMOUNT**
	$
	$
	$
	$
TOTAL	$

OTHER INSURANCE / BENEFITS

Are you claiming insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, sports body or any income replacement.	**YES / NO**
Provide Details	

Name of insured organisation/employer & telephone no.	
Name of Insurer & Telephone number	
Type of cover	
Amount claimed per week	**$ Per week**
Do you have private health insurance?	**YES / NO**
Provide Details	
Do you have ambulance cover?	**YES / NO**
Provide Details	

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.

Employer's Name	
This is to Certify that	**Name** **Address**

a) has been unable to attend his/her occupation as a result of Injury or Sickness from	
b) until	
His/Her average Gross Weekly Salary at the time of this accident/sickness was	AUD $
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?	**YES / NO**
In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission?	**YES / NO**

SIGNATURE OF EMPLOYER OR SUPERVISOR:	
NAME OF EMPLOYER OR SUPERVISOR (PLEASE PRINT)	
ADDRESS	
TELEPHONE NUMBER	
DATED	

PRIVACY CONSENT - CLAIM ASSESSMENT

Protection of My Privacy
Acknowledgement and Consents

By signing this form I agree that Gallagher Broking Services (including the Insurers they represent and claims management services) and third parties such as my insurance broker, claims reference services, government organisations (for example social security agencies or taxation offices), any forensic accountant retained by Gallagher, my employers (past and present), my accountant, any business which provides information about the commercial activities of persons and if I am or have been bankrupt, the trustee of my estate ('the Parties') may exchange with each other any information about me, excluding health or other sensitive information, including:

- Any information provided by me in relation to my claim;
- Any other personal information I provide to any of them or which they otherwise lawfully obtain about me;
- Any information relating to this insurance or any other insurance held by me or on my life, including terms and conditions and claims history;
- Details of my employment, including position, period of employment, remuneration, hours worked and duties performed; and
- Any information relating to my income and solvency.

I agree that any information referred to above can be used by the Parties and any Service Provider (as identified below) for assessing the claim or my entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

I agree that Gallagher may exchange my personal and/or sensitive information, for the purposes of assessing the claim or my entitlement to benefits with:

- Any investigator appointed by Gallagher to investigate the claim;
- The Health Record Holders;
- The Health Insurance Commission;
- Other insurers;
- Re-insurers;
- Any private or government organisation which investigates fraud including the police; and
- Any witness identified by me.

If I have identified any person as a witness, I agree to ensure that each person is made aware that:

- I have identified him/her as a witness in relation to the claim;
- Gallagher holds a record of their personal information for this purpose; and
- He/she may contact Gallagher or request access to his/her information,

If Gallagher engage anyone (a 'Service Provider') to do something on its behalf (for example technology providers) then I agree to them exchanging any information referred to above, with each other.

I understand Gallagher might give any information referred to above to entities other than the Parties, the Service Providers, the Health Record Holders and the other persons/organisations referred to above where it is required or allowed by law or where I have otherwise consented. I understand that I can access most personal information that members of Gallagher hold about me (sometimes there will be a reason why that is not possible, in which case I will be told why). I understand that if I fail to provide any information requested in this form, or do not agree to any of the possible exchanges or uses detailed above, Gallagher may be unable to assess the claim.

MEDICAL AUTHORITY, DECLARATION AND POWER OF ATTORNEY

I DECLARE THAT,

- I will use my best endeavors and render all reasonable assistance and co-operation to Corporate Services Network in the assessment of my claim;
- the information supplied by me is true and correct and that I have not withheld any information likely to affect the acceptance of the claim;
- I understand that the claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts;
- I understand that by investigating my claim or by accepting proofs of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defense of any claim arising under the policy.

I hereby appoint CSN to do everything necessary or expedient to:

- give effect to the transactions contemplated by the authorisations described; and
- execute and deliver any other documents or do any other acts referred to in the transactions described.

I hereby authorise any person, corporation, institution, private or government organisation, whether named by me or not, to provide such information as CSN in its absolute discretion considers relevant for its assessment of initial or ongoing benefits for my claim including, without limitation:

- all medical, surgical or other information concerning myself, my medical history, any treatment received by me and any medication taken or prescribed for me (at any time);
- my Health Insurance claims history, including Medicare;
- any information in relation to my assets, liabilities, earnings, salary or wages (at any time);
- any information from third persons who may have information relevant to my eligibility to receive a benefit, or my entitlement to receive an ongoing benefit.

SIGNATURE OF CLAIMANT:		**DATED**	
SIGNATURE OF WITNESS:		**DATED**	

MEDICAL PRACTITIONER'S STATEMENT TO COMPANY

The claimant is responsible for any fee for this statement.

Patients Name			
Usual occupation:		**Date of Birth**	
Height		**Weight**	
Diagnosis (if fracture or dislocation, describe nature and location i.e.: Simple, Compound)			
Provide Details			
Cause:-			
If available please provide a copy of X-ray report	Is this condition ☐ an injury or ☐ an illness		
Does the patient have any other injury or illness that is contributing to the condition? e.g. Osteoporosis	☐ **Yes** ☐ **No**		
Provide Details			
Is condition due to injury or sickness arising out of the patient's employment?	☐ **Yes** ☐ **No**		
Provide Details			
Was the disability sports related?	☐ **Yes** ☐ **No**		
Provide 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?	☐ **Yes** ☐ **No**		
Provide Details			
Name of patient's usual doctor/medical practice			
How long have you been the patient's usual doctor/medical practice?			
Has the patient been hospitalized	**Date of Admission**	**Date of Discharge**	
Name of Hospital			
Has the patient had surgery or is it anticipated?	☐ **Yes** ☐ **No**		
Provide Details			
Date performed or anticipated	**Name of hospital?**		
Did you provide other medical services (including pathology) to the patient?	☐ **Yes** ☐ **No**		
Provide Details			
Was the patient referred by you or to you?	☐ **Yes** ☐ **No**		
Provide Details	**Doctors details**		
Is the patient still disabled?	☐ **Yes** ☐ **No**		
If yes	**Totally disabled (unable to perform any part of their occupation)**	**to**	
	Partially disabled (able to perform part of their occupation)	**to**	
If partially disabled, what duties could the patient perform and for how many hours a week?	**Hours**		
Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, and Workers Compensation insurer, Social Security, sports body or any other insurance body?	☐ **Yes** ☐ **No**		
NAME OF MEDICAL PRACTICTIONER (PRINT)			
QUALIFICATIONS			
SIGNATURE OF MEDICAL PRATICTIONER			
ADDRESS			
TELEPHONE NUMBER:			

WHAT TO DO NEXT

1. Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employers and Medical Practitioner have signed this form.

2. To lodge this claim, send the completed claim form and supporting documentation via email to claims_GriffithUniversity@ajg.com or alternatively via fax or registered mail to the below address.

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DISPUTES

Gallagher has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.

Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.

If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access the insurer's Internal Dispute Resolution Committee which is set up to hear claims of this nature.

If You or an Insured Person are still dissatisfied, the complaint may be referred, at no cost to you, to the Financial Ombudsman Service ***(the FOS).***

PRIVACY

Gallagher has always protected the privacy of personal information of our valued clients. The standards by which we handle this personal information have now been set by the Privacy Act and the National Privacy Principles (NPP), which came into effect on 21st December 2001.

All Staff, Broker Representatives, Agents and Contractors have agreed to hold all information in confidence and not use it for any purpose except to carry out the service they are providing. We do not sell or share names, addresses or any other information with third parties, except to the extent necessary to complete our obligations as an Underwriting Agency or as stated in this document.

How & why do we require your Personal Information
We collect information either directly from the relevant individuals or in some cases, from third parties. They may provide information for someone else requiring the benefit of the services that we offer, such as a nominated driver, director or officer or other staff member.

The information is collected to allow us to provide our insurance services including to arrange and place insurance cover, assess and underwrite risks, and to properly administer your claims.

What we expect of you
When you provide us with information about other individuals, we rely on you to have made, or make them, aware that you will or may provide their information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties will use it for and how they can access it. If it is sensitive information, we rely on you to have obtained consent to the above. If you have not done these things, we expect you to tell us before you provide the relevant information. If you collect, use, disclose, or handle personal information on our behalf, or receive it from us, you & your representatives must meet the relevant requirements of the NPP set out in the Privacy Act 1988 and only use and disclose it for the purposes we agree to.

Transfer of information overseas
We may transfer your personal information overseas where it is necessary to provide our service. Some insurers or reinsurer's are based overseas and we need to provide your personal information to them to arrange your cover.

Opting out
We regularly distribute to our clients information about our products & services, such as newsletters, which we believe may be of interest to you. If you do not wish to receive this additional information, please contact our office.