caip. Income Protection

FULLERTON HEALTH | CORPORATE SERVICES

Injury and Sickness - **Claim Form**

This claim form consists of 3 parts and must be completed in full.

- Your claim cannot be assessed until all sections are completed the original form is submitted.
- To have a valid claim, you must be medically disabled from work for at least the elected waiting period.
- Original medical certificates or supporting documentation must be submitted with the form.
- A wage report showing the last 12 months of wages is required as part of Section C.

1. **You** complete Section A, please ensure all questions are answered.

2. Your **Medical Practitioner** completes Section B.

3. Your **Employer** is to complete Section C. Please liaise with your HR representative to complete this section.

Please return the completed claim form to:

CAIP Services
PO Box 351
Bondi Junction NSW 1355

1 Section A – Claimant Statement

All questions must be completed and declaration signed for submission

Claimant's Details

Given name:		Surname:				Title:	
Address:							
Suburb:		State:		Postcode:			
Home phone:		Mobile:					
Fax:		Gender:	☐ M ☐ F	Date of Birth:	/ /		
Email:				Height:	Cm	Weight:	Kg
Name of Super fund				Member No.			
Name of Union (If applicable)				Member No.			

Employment Details

Employer name:					
Name of project working on:					
Street Address:					
Suburb:		State:		Postcode:	
Work phone:		Work fax:			
Date you commenced employment:	/ /				
Occupation at the time of disablement:					
Describe your usual duties:					

Are you still employed?	☐ Yes ☐ No	If No, when did you cease employment?	/ /	
Are you self-employed?	☐ Yes ☐ No	Are you a sole trader?	☐ Yes ☐ No	
Do you pay yourself a wage through your own Company?	☐ Yes ☐ No			
Are you employed under an EBA or individual workplace contract?	☐ Yes ☐ No	If Yes, with whom:		

PLEASE ENSURE ALL QUESTIONS ARE ANSWERED TO AVOID ASSESSMENT DELAYS

If you have any questions, please don't hesitate to contact our claims department on 1300 365 948

caip. Income Protection

FULLERTON HEALTH | CORPORATE SERVICES

Bank Details

Name of financial institution:			
Name on account:			
BSB number:		Account No.	

Medical Details

Is your condition an	☐ Injury OR ☐ Sickness
Description of Injury or Sickness:	

If your condition is an Injury, please state exactly how, when and where it occurred:

When did symptoms first occur for your medical condition?	Date: / / Time: :
When did you first consult a doctor for this medical condition?	Date: / /
When was your last day at work as a result of this condition?	Date: / /
Have you returned to work?	☐ Yes ☐ No
If Yes, please provide the date you returned	/ /
If No, please advise the date you expect to return	/ /
In your opinion, do you believe your condition is work related?	☐ Yes ☐ No
In your opinion, do you believe your condition is a result of playing sports?	☐ Yes ☐ No
Is or was surgery required for your condition?	☐ Yes ☐ No If Yes, when was/is surgery? / /
Have you had a similar condition in the past?	☐ Yes ☐ No

If Yes, please complete the details below for the physician/specialist(s) you attended.

DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED
			/ /

General Practitioner Details (please give a history for over 5 years)

If you've attended more than 1 medical practitioner over the past 5 years, please attach a list with the claim form, please note if a complete medical history is not provided, your claim maybe delayed while we obtain a full Medicare history.

Doctors name		Practice/Hospital			
Address					
Suburb		State		Postcode	
Phone number		Fax number			
Date first attended	/ /	Date last attended	/ /	Yrs attended	

Other Benefit Details

Question	Yes	No
Have you or are you planning to lodge motor accident compensation claim?	☐ Yes	☐ No
Have you or are you planning to lodge a sports insurance claim?	☐ Yes	☐ No
Have you or are you planning to lodge a Workers Compensation claim?	☐ Yes	☐ No
Have you or are you planning to lodge a claim with any government benefits?	☐ Yes	☐ No
Are you making or entitled to lodge a claim with any other insurer or compensation benefit?	☐ Yes	☐ No

If you have answered Yes to any of the above, please complete the below and provide details of your claim. For example an acceptance or decline letter and copies of any benefits.

Field			
Insurer/Company name			
Type of claim			
Address			
Contact person		Contact No.	
Have you or are you planning to receive any employer benefit? Sick leave etc.		☐ Yes	☐ No

Authorised Representative's (this section is optional)

Complete this section if you wish to authorise a family member or friend to assist you with the claims process, as it is required to disclose any personal information about your claim which includes medical, financial, employment and insurance information.

Field			
Name of authorised representative			
Representative's relationship to you		Representative's date of birth	/ /
Do you consent to us contacting you by email	☐ Yes	☐ No	
Do you consent to us contacting you by SMS	☐ Yes	☐ No	

Declaration & Authorisation

1. I understand that by investigating my claim or by accepting proof of my claim, FHCS has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy
2. I agree to FHCS using and disclosing my personal information pursuant to FHCS's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to FHCS's Privacy Officer.
3. I authorise any person or entity, including those referred to above, to provide to FHCS such personal information (including health information) as FHCS in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.
4. I will use my best endeavours and render all reasonable assistance and cooperation to FHCS in the assessment of my claim. I 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.
5. I understand that if I do not consent to the terms of this authority or revoke my consent, FHCS may not be able to process or assess my claim.
6. I appoint FHCS to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Field			
Name (please print)			
Signature		Date	/ /

caip. Income Protection

FULLERTON HEALTH | CORPORATE SERVICES

2 Section B – Doctor's Statement

All questions must be completed by your regular treating doctor

*Please note any and all charges for the completion of this form, is the full responsibility of the patient.

Patient's Details

Patient's given name		Surname			
Patient's address					
Suburb		State		Postcode	
Gender	☐ Male ☐ Female	Date of birth	/ /	Age	

Are you the patient's regular doctor?	☐ Yes ☐ No
How long has this patient been attending your practice/hospital?	Years Months
The medical condition currently disabling the patient from work is a	☐ injury ☐ Sickness
When did the patient first attend your practice for the current condition?	/ /
What date did the patient's symptoms first appear or injuries occur?	/ /
When was the patient diagnosed?	/ /
What date was the patient incapacitated from work for this condition?	/ /

For this condition, please list all dates the patient attended your practice/hospital for treatment and advice. (if insufficient space, please provide attached report listing all dates of treatment and advice)

1. / /	2. / /	3. / /	4. / /	5. / /
6. / /	7. / /	8. / /	9. / /	10. / /
11. / /	12. / /	13. / /	14. / /	15. / /

Please state the primary medical diagnosis disabling the patient

If any, please list all other medical condition affecting a return to work

What is the cause of the patient's current disablement?

Please provide details of the patient's symptoms

Please advise the prescribed medication & treatment given to the patient

Are there any complications regarding the patient's recovery?	☐ Yes ☐ No
If Yes, please give details.	
Has the patient had a similar condition in the past?	☐ Yes ☐ No

If Yes, please give details below of the similar condition, time of onset and contact details of the physician/specialist attended for that condition.

Medical condition		When did the condition occur	/ /

DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED
			/ /

In your professional opinion, do you believe this condition is work related?	☐ Yes ☐ No
In your professional opinion, do you believe this condition is sports related?	☐ Yes ☐ No
Has the patient been following your prescribed medication and treatment?	☐ Yes ☐ No
If No, give details of when the patient did not follow the medical advice.	
Have you advised the patient that their condition no longer requires any treatment or advice?	☐ Yes ☐ No
If Yes, please advise the date you gave this advice to the patient	/ /
In regards to the patient's medical condition, have you issued any certificates or forms to any other insurance companies, workers compensation or government benefit entities?	☐ Yes ☐ No
If Yes, please advise to which company.	
In your opinion, does the patient require surgery for this condition?	☐ Yes ☐ No
If Yes, has surgery been undertaken? ☐ Yes ☐ No Please advise the date of surgery?	/ /
Has the patient been referred to a specialist for the condition?	☐ Yes ☐ No
If Yes, please give contact details.	
In your professional opinion, when will the patient be fit to return to work on alternative duties?	/ /
In your professional opinion, when do you believe the patient will be fit to return to work for full duties?	/ /
Please comment on the patient's current prognosis?	
I certify the above patient was/is totally disabled from returning to work for the period	/ / TO / /
I certify the above patient was/is partially disabled from returning to work for the period	/ / TO / /

Doctor's Declaration and Authority

I hereby certify that I am a registered medical practitioner and have examined the above named patient and that all information that I've supplied is true and correct. I also acknowledge that CAIP Services may provide copies of these forms to any required representative and or third parties deemed necessary to assist the ongoing assessment of the claim.

Practice/Hospital name					
Name (please print)					
Address					
Suburb		State		Postcode	
Phone number		Fax number			
Email					
Medical qualifications					
Signature		Date	/ /		

If you have any questions, please don't hesitate to contact our claims department on **1300 365 948**

caip. Income Protection

FULLERTON HEALTH | CORPORATE SERVICES

3 Section C – Employer's Statement

(Must be completed by your employer paymaster/manager only)
A full 12 month wage report prior to the disablement and a job description is to submitted with the claim form

Employee's Details

Employee's name		Employee's number	
Description of Injury or Sickness			
Employment type	☐ Permanent ☐ Casual ☐ Contractor		
Please advise the employee's contract of employment end date – if applicable	/ /		
Current work status	☐ Employed ☐ Resigned / / ☐ Terminated / /		
Date commenced employment	/ /	Date of Injury or Sickness	/ /
Date last actively at work	/ /	Date incapacity commenced	/ /
Was the employee on alternative duties prior to the incapacity date?	☐ Yes ☐ No If Yes, from when? / /		
Expected return to work date	/ /	Employee's gross weekly earnings	$
If the employee is fit for alternative duties are you prepared to take him/her back on alternative duties?	☐ Yes ☐ No		
In respect of this condition has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?	☐ Yes ☐ No		
If Yes, please advise when and to which company			
Has the employee received any employer entitlements (normal pay, sick leave, annual leave etc.) since the incapacity commenced, if Yes please complete details below & provide an additional wage report for the period?	☐ Yes ☐ No		

TYPE OF EMPLOYER BENEFIT	AMOUNT RECEIVED	DATE RECEIVED FROM	DATE RECEIVED TO
	$	/ /	/ /
	$	/ /	/ /

Does your company have Income Protection policy, under an EBA?	☐ Yes ☐ No		
Do you believe the employee's condition is work related?	☐ Yes ☐ No		
Is your company self-insured for workers compensation?	☐ Yes ☐ No		
Is the employee currently on workers compensation?	☐ Yes ☐ No		
Does your company top-up workers compensation claims?	☐ Yes ☐ No		
Name of Workers Compensation		Policy No.	
Project name employee was working on		Project State	
Date commenced work on project	/ /	Completion date of project	/ /
Employee's estimated demobilization date from site	/ /		

Employer's Declaration and Authority

I am authorised to complete this form on behalf of the employer. All information I've supplied is true & correct. I acknowledge that CAIP Services and their claims management team may provide these forms to required representatives or third parties as necessary to assist the ongoing assessment of the claim.

In reference to this claim, I would prefer the benefit to be paid directly to the	☐ Claimant ☐ Employer		
Company name			
Paymaster/Manager name		Job title	
Address			
Suburb		State	Postcode
Phone number		Fax No.	
Email			
Signature		Date	/ /

Privacy Collection Statement

At CAIP, We are committed to protecting Your privacy. We collect, use, store and disclose personal information in accordance with the *Privacy Act 1988* (Cth) ('the Act') and the Australian Privacy Principals. In dealing with us, you consent to us using and disclosing your personal information as set out in this statement. This consent remains valid unless you alter or revoke it by giving written notice to CAIP's Privacy Officer. However, should you choose to withdraw your consent, we may not be able to provide insurance services to you.

CAIP's Privacy Policy is available at www.caip.com.au or by calling CAIP, it sets out how:

- We protect Your personal information;
- You may access Your personal information;
- You may correct Your personal information held by Us;
- Privacy complaints process and how We will deal with such a complaint.

We need to collect, use and disclose Your personal information (which may include sensitive information such as health information or criminal history) in order to arrange insurance on your behalf and provide general advice on the insurance products. We will provide your personal information to insurers who we ask to quote for your insurance cover. The information is required to enable the insurers to decide whether to insure you and on what terms.

When you make a claim under your policy, we may assist you by collecting information about your claim. Sometimes we also need to collect information about you from third parties. We may provide this information to your insurer (or anyone your insurer has appointed to assist it to consider your claim, eg Claim Managers, loss adjusters, medical practitioners etc) to enable the insurer to consider your claim.

Sometimes we may use your contact details to send you direct marketing communications including updates and newsletters that are relevant to the services we provide. We always give you the option of electing not to receive these communications in the future. You can unsubscribe by notifying us and we will no longer send this information to you.

The primary purpose for Our collection and use of Your personal information is to enable Us to provide insurance services to You.

We may disclose Your personal information to third parties who assist Us in providing the above services. These parties (which include Our related entities, distributors, agents, insurers and service providers) will only use the personal information for the purposes We provided it to them for (unless otherwise required by law). Some of these third parties may be located outside of Australia such as the United Kingdom and Europe. In all instances where personal information may be disclosed to third parties who may be located overseas, We will take reasonable measures to ensure that the overseas recipient holds and uses Your personal information in accordance with the consent provided by You and in accordance with Our obligations under the Act.

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from Your representatives or co-insured's). If You provide information for another person You represent to us that:

- You have the authority from them to do so and it is as if they provided it to Us;
- You have made them aware that You will or may provide their personal information to Us, the types of third parties We may provide it to, the relevant purposes We and the third parties disclose it, the use, and how they can access and correct 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.

CAIP's Privacy Policy contains information about how to access and correct the personal information about You and also how to complain about a privacy issue. If You would like additional information about privacy or would like to obtain a copy of the Privacy Policy, please contact CAIP's Privacy Officer on the contact details below or go to CAIP's website: www.caip.com.au

CAIP 's Privacy Officer on 02 8789 0500 or email privacyofficer@caip.com.au