

traumatic injury claim form

Wesfarmers General Insurance Limited trading as Lumley Insurance, ABN 24 000 036 279, AFS Licence no. 241461, Freecall 1300 651 654
Level 2, 99 Melbourne Street, South Brisbane, QLD 4101 or GPO Box 524 Brisbane, QLD 4001 Fax 07 3307 4880

IMPORTANT INFORMATION - Read before completing this form.

Please answer ALL relevant questions concerning this claim and make sure the Employer complete ALL the relevant questions as well.

Failure to complete ALL the relevant questions will only delay this claim. If a question is not applicable to you please write N/A or strike through the answer.

Please PRINT your answers and use a black or blue pen. Please tick boxes (✓) where applicable

NOTE: The issuing of this form is not an admission of liability

1. Personal Statement

Deceased's name

Residential street address

Suburb

State

Postcode

Date of birth

Sex

 Male Female

Usual occupation

Employer's name

Location / department

Employer's phone number

2. Statement of claim *(to be completed by next of kin or authorised legal representative)*

Date of Accident/Injury (dd/mm/yyyy) Time of accident

 am/pm

Date of death *(if different to date of the Accident/Injury?)* (dd/mm/yyyy)

Please describe the cause of death *(e.g. fell from ladder, motor vehicle accident, etc)*

Please describe how the Accident occurred (please use a separate page if necessary)

Where did the Accident occur (location or address)?

Please state whether accident happened at work or whilst travelling to or from work or other circumstances (please specify)

Name and address of witnesses to the Accident (attach a separate page if necessary)

| Name | Address |
|------|---------|
| | |
| | |
| | |

Was hospitalisation required? Yes No

Was the use of an ambulance required? Yes No

Name of hospital and dates confined From To

Is there any entitlement to claim in respect of this Accident/Injury from any of the following?

Workers Compensation Yes No

Third Party Insurance Yes No

Other Insurance Yes No

If Yes, please provide details (and dates where applicable)

3. Details of Person making this Claim

Name

Relationship to deceased

Residential address

Home telephone Work telephone Mobile number

Fax Number Email address

Please attach a copy of any documents proving you legal authority to act on behalf of the deceased.

4. Summary of Claim

I am claiming the following benefits under this Insurance.

| | |
|------------------------|----|
| Capital Benefit | \$ |
| Other (Please specify) | \$ |
| TOTAL | \$ |

5. Declaration

I hereby authorise any hospital, physician, insurer, Health Insurance Commission, employer or other person who has attended the deceased to supply Wesfarmers General Insurance Limited or its representative with any and all information with respect to any injury or sickness, medical history, consultation, prescriptions or treatment, including copies of all hospital and/or medical records, including any and all financial information and details of any paid entitlements with respect to this claim. I agree that a photostat or facsimile copy of this authorisation shall be considered as effective and valid as the original.

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail and I agree that if I have made, or in any further declaration in respect of the said claim make any false or fraudulent statements or suppress, conceal or falsely state any material fact whatsoever the Policy shall be void and all rights to recover there under or in respect past or future claims will be forfeited.

Please Print Name

Signature

Date

Relationship to deceased (please tick)

- Next of kin
 Legal representative of the estate

Privacy

The Privacy Act 1988 (as amended) seeks to ensure the confidentiality and security of any personal information. We are committed to ensuring that confidentiality and security.

Our Privacy Policy detailing our handling of personal information is available on request. You may request access to information held by us about you, by contacting us. You may also access our Group's Privacy statement on our Website at www.lumley.com.au

IMPORTANT INFORMATION

Please make sure that all questions have been answered and the claim form is completed in full.

If this claim form is not completed in full it will only delay the processing of this claim.

Additional documentation we will require include:

1. Certified copy of the death certificate
2. Certified copy of the police report (if applicable).
3. Certified copy of the coroners report (if applicable).

6. Request for payment by Electronic Funds Transfer (please complete the following)

Name of Bank

Bank Address

BSB Number

Account Number:

Name of Account in full

Signature

Date

Name (Please Print):

To be completed by the Employer (if applicable)

When did the claimant/deceased commence employment with the company (dd/mm/yyyy)

Please describe the claimant's/deceased's usual occupation listing details of primary responsibilities.

Is there any additional information you would like to provide in relation to the submission of this claim?

I do solemnly and sincerely declare that the foregoing particulars are true and correct in every detail.

Name of Company

Address

Signature of supervisor or paymaster

Date

Name of supervisor or paymaster (please print)

Telephone number

Fax number

Email