

journey injury claim form

Wesfarmers General Insurance Limited, ABN 24 000 036 279, AFS Licence no. 241461, Freecall 1300 651 654

IMPORTANT INFORMATION - Read before completing this form.

(The issuing of this form is not an admission of liability)

This form should be completed in FULL and forwarded to:-

Wesfarmers General Insurance Ltd trading as Lumley Insurance

Level 2, 99 Melbourne Street, South Brisbane, QLD 4101 or GPO Box 524 Brisbane, QLD 4001

Freecall 1300 651 654 Fax 07 3307 4880

Please answer ALL relevant questions concerning your claim and make sure your Employer and Doctor complete ALL the relevant questions as well. Failure to complete ALL the relevant questions will only delay your claim.

Please tick boxes where applicable

1. Personal Statement

Surname

Given Names

Residential address

Suburb

State

Postcode:

Telephone

Mobile

Occupation

Describe your usual duties

Date of Birth

Male

Female

Height

cm

Weight

kg

Name of your employer

Address

Suburb

State

Postcode:

Telephone number

Are You Registered for GST?

Yes

No

If YES, please enter the Australian Business Number (ABN) and Input Tax Credit (ITC) entitlement percentage below

ABN

Input Tax Credit

%

If you fail to advise the availability of an Input Tax Credit or understate its availability, then you may have a liability to pay tax on the claim payment.

2. Confirmation of Membership - to be completed by your union official

Membership number

Is this member financial?

Yes No

Name of Union

I HEREBY CERTIFY THAT the above member is a financial paid up member of the Union

Name of Official

Signature

Date

Witness

Date

3. Details of this Claim

Date of accident

Time of Accident

 am/pm

Where did the accident occur?

Did the Police attend the accident?

Yes No

If YES, please give details below

What Police Station

Attending Officers Name

Police Case Reference Number (if given)

From what address did your journey commence from before the accident

Is the above address your usual place of residence or place of business activity?

Yes No

If NO, please give details

What address were you travelling to?

Is the above address your usual place of residence or place of business activity?

Yes No

If NO, please give details

What time did you commence your journey before the accident?

 am/pm

If the accident occurred on your way home, what time did you commence work on that day?

 am/pm

What time did you finish work on that day?

 am/pm

Please describe the method of transport (e.g. car, motorcycle, etc)

Please detail the streets/roads you use between home and work or vice versa, in order.

Did you divert from your usual journey?

Yes No

If YES, please give reason why

Please give a full description of injury for which you are claiming

How were you injured?

What were you doing when you were injured?

If the accident was caused by a motor vehicle accident were you required to undergo a breath and/or blood test?

Yes No

If YES, please attach a copy of the result to this claim form.

When did you first consult a Doctor for your injuries?

Date Time: am/pm

When did you become unable to work from the injuries you sustained in the accident?

Date Time: am/pm

If you are still disabled, when do you expect to return to work?

Date Time: am/pm

If you were admitted to a hospital, or treated as an outpatient, please give details:

Name of Hospital

Address

Date/Time Admitted am/pm

Date/Time Discharged am/pm

Inpatient Outpatient

Please give details of all the Doctors that Attended you.

Doctors Name

Address Telephone number

Doctors Name

Address Telephone number

Doctors Name

Address Telephone number

Have you ever had this or a similar condition in the past?

Yes No

If YES, please give details

Condition Date first treated

Treating Doctor Telephone number

4. Witnesses

Please give details of person who witnessed the accident below

Name	Phone number	
<input type="text"/>	<input type="text"/>	
Address	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Phone number	
<input type="text"/>	<input type="text"/>	
Address	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>
Name	Phone number	
<input type="text"/>	<input type="text"/>	
Address	State	Postcode
<input type="text"/>	<input type="text"/>	<input type="text"/>

5. Other Insurance

Do you have any other insurance Policy that provides weekly benefits in the event of an injury? Yes No

If YES, please give name of insurance company

Do you have any other insurance Policy that provides lump sum benefits in the event of an injury? Yes No

If YES, please give name of insurance company

Are you entitled to make claim under any other insurance or compensation scheme in respect of your injuries? Yes No

If YES, please give details of who you could claim from (workers compensation, transport accident authority, etc) and their contact details

Have you ever had an injury claimed before? Yes No

If YES, please provide details

6. Earnings Declaration

IMPORTANT: You are required to supply proof of your earnings (please refer to the Policy Wording for the definition of "Earnings") to support your claim. You need to submit copies of your personal and/or business income tax returns for the full financial year immediately preceding the injury which you are now claiming.

SELF EMPLOYED PERSONS ONLY TO COMPLETE THE FOLLOWING

Business/Trading Name

Address

State Postcode Phone number

<input type="text"/>	<input type="text"/>	<input type="text"/>
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Was the business fully operational and were you fully employed at the time of the accident? Yes No

If NO, please provide details

Does your business have Workers Compensation insurance?

Yes No

Please state your current weekly Earnings

\$

Accountant's Name

Phone number

<input type="text"/>	<input type="text"/>
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EMPLOYED PERSONS ONLY – TO BE COMPLETED BY YOUR EMPLOYER

Employers name

Address

State

Postcode

Phone number

Please state the employees current weekly Earnings

Is the employee entitled to Workers Compensation benefits?

 Yes No

If YES, please provide details of entitlement or any payments:

Amount of weekly Earnings

Total weekly Earnings paid to date

Was the employee employed by you at the time of the accident?

 Yes No

What was the employees weekly Earnings at the date of injury?

Please advise the number of days of accrued sick leave

 days

The employee has been employed since

Your Name:

Your Position at the Company

Phone number

Signature

Date

7. Authority and Declaration by Claimant

I hereby authorise any hospital, physician, insurer, Health Insurance Commission, employer or other person who has attended me to supply Wesfarmers General Insurance Ltd trading as Lumley Insurance 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 my hospital and/or medical records, including any and all financial information and details of any paid entitlements with respect to the claimed injury or sickness. 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 to unjustly seek any benefit from the claim I am making.

Please Print Name

Signature

Date

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.

The Lumley Insurance 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 Privacy statement on our Website at www.lumley.com.au

IMPORTANT NOTICE

PLEASE MAKE SURE THAT ALL QUESTIONS HAVE BEEN ANSWERED AND THE CLAIM FORM IS COMPETED IN FULL. IF THIS CLAIM FORM IS NOT COMPLETED IN FULL IT WILL DELAY THE PROCESSING OF YOUR CLAIM.

8. 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:

Name (Please Print):

Date:

9. Medical Practitioners Statement – to be completed by your doctor

Patients Name:

Patient Date of Birth

Male Female

Patient Height

 cm

Patient Weight

 kg

What is your diagnosis of the Patients condition?

Do you consider the Patients condition to be as a result of an Injury? (Please give reasons why)

What do you think caused the Patients condition?

What date did you first consult with the Patient regarding this condition

To your knowledge, please state the date the Patient first obtained medical treatment or advice for treatment in relation to this condition?

Has the Patient ever suffered a similar condition, and if so does it relate to his present condition?

How long has this Patient attended your practices?

Years

Months

What treatment is the Patient receiving for this condition?

Please provide any relevant medical history that will assist us with this Patients claim

What investigations have been made in determining a diagnosis for the Patients condition?

Are you the Patients regular treating Doctor?

Yes No

If NO, please advise name and number of the Patients regular treating Doctor:

MEDICAL PRACTITIONERS STATEMENT – CONTINUED

Do you consider the Patient to be wholly and continuously prevented from engaging in his/her usual occupation as a result of this condition?

Yes No

If YES, for what period:

From to

Do you consider the Patient to be able to carry out a substantial part of his/her usual occupation as a result of this condition?

Yes No

If YES, for what period

From to

On what date do you consider the Patient will be able to return to work

Is the Patients condition related to the accident?

Yes No

If NO, please explain why

Name

Qualifications

Phone number

Fax number

Email

Address

State

Post Code

Signature

Date