



(c) under any other State or Commonwealth law which provides a weekly benefit?

No  Yes

If **Yes** state:

Name of company or department

Amount of weekly compensation

\$

(d) any Transport Accident Compensation scheme?

No  Yes  Name

Name of doctor **first** consulted for the relevant disability

Date of this first consultation (dd/mm/yyyy)

Address of the doctor first consulted

Names and address of other doctors consulted

Name and address of your usual medical practitioner

**Please COMPLETE if disability is due to SICKNESS**

Nature of your sickness

On what date did first symptoms occur? (dd/mm/yyyy)

Are you still being treated for this sickness

No  Yes

Have you previously suffered from the same or similar sickness?

No  Yes  If **Yes** state:

Date of each occurrence (dd/mm/yyyy)

Period of disability resulting from sickness

Have you been advised to have any surgical operation in connection with the present sickness?

No  Yes  If **Yes** state:

Nature of operation

Date performed / proposed (dd/mm/yyyy)

Have you been wholly and continuously prevented from engaging in your usual occupation as the sole result of this sickness? (we refer to this as "TOTALLY disabled" below.)

No  Yes  If **Yes** state dates: (dd/mm/yyyy)

From

To

If you are still TOTALLY disabled when do you expect to perform SOME part of your usual occupation or other occupation for which you are reasonably qualified by experience, education or training? (dd/mm/yyyy)

**Please COMPLETE if disability is due to an INJURY**

Date of injury (dd/mm/yyyy)

Time of injury

am/pm

Were you at work at the time of the injury?

No  Yes

Where did the injury occur (full address)

Postcode

How did the injury happen?

What caused it?

Describe the injuries you received

Was an ambulance called? No  Yes

Did the police attend? No  Yes

When did you first seek treatment for this injury? (dd/mm/yyyy)

Have you previously suffered the same or similar injury? No  Yes

Date (dd/mm/yyyy)

Are there any witnesses to the injury? No  Yes

Name(s)

Address

Postcode

How long have you been wholly and continuously prevented from engaging in your usual occupation as a sole result of this injury (we refer to "wholly and continuously" as TOTALLY disabled" below)

From (dd/mm/yyyy)

To (dd/mm/yyyy) inclusive

How long have you been PARTIALLY incapacitated from engaging in the duties of your usual occupation?

From (dd/mm/yyyy)

To (dd/mm/yyyy) inclusive

Describe fully the daily duties of your usual occupation you cannot perform whilst PARTIALLY incapacitated.

How many hours per week are you able to work whilst PARTIALLY incapacitated?

If you are still totally incapacitated when do you expect to perform SOME part of your usual occupation or other occupation for which you are reasonably qualified by experience, education or training? (dd/mm/yyyy)

### 3. Privacy

We respect your privacy and comply with the Privacy Act and the National Privacy Principles.

We collect personal information for the purpose of providing insurance, including arranging insurance, policy administration and claims handling. We also collect your personal information to conduct market or customer satisfaction research and to develop identifying products and services that may interest you.

We disclose personal information to persons we deal with in providing our services to you, for example, reinsurers, insurance intermediaries, insurance reference bureaus, credit reference agencies, our and your advisers and those involved in the claims handling process, for the purpose of assisting us and them in providing relevant services and products and for the purposes of litigation. We limit the use and disclosure of any personal information provided by us to them to the specific purpose for which it is supplied. By providing your personal information to us, you consent to us making these disclosures.

Without this information we may not be able to provide you with the services you require or process your claim.

When you give us personal 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 and 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 you have not done or will not do either of these things, you must tell us before you provide the relevant information.

If you would like a copy of our Privacy Policy, would like to access or correct your personal information, or opt out of receiving materials we send, please contact us.

### 4. Authorisation and Declaration from Insured Person

**To whom it may concern:**

**(a) I authorise any hospital, physician or any other medical provider who has attended me or examined me to furnish Lumley Insurance such details of my medical history as they may require; and**

**(b) I authorise my employer or any principal to provide Lumley Insurance with details of my terms of employment, including details of my earnings.**

**A photocopy of this authority will be sufficient for you to release this information.**

I declare that I have read the Privacy Statement attached to this claim form and consent to the collection, use and disclosure of my personal information in the manner described in that Privacy Statement.

I do solemnly and sincerely declare that all of the above answers are true and correct in every detail and I have not suppressed or concealed any information that is material to this claim.

**I understand that false declarations may result in Lumley Insurance being able to refuse to pay a claim.**

Insured person's signature

Date (dd/mm/yyyy)

Insured person's name in full

Witness signature

Date (dd/mm/yyyy)

Witness name in full

**Lumley Insurance does not admit liability under the policy by the issue of this claim form.**

***If you fail to notify us of any occurrence, which may give rise to a claim within 30 days, we may refuse to pay or reduce any claim to the extent permitted by law.***

**PLEASE PROVIDE ORIGINAL MEDICAL CERTIFICATES, HOSPITAL ADMITTANCE REPORT, MEDICAL REPORTS, X-RAYS, SCANS OR POLICE REPORTS TO SUPPORT YOUR CLAIMS (THESE ITEMS ARE AT YOUR OWN EXPENSE).**

**IF ANY SECTIONS ARE NOT FULLY COMPLETED OR ARE LEFT BLANK THE FORM WILL BE RETURNED FOR COMPLETION.**