First Notice of Claim for Illness or Injury

Latitude Insurance
GPO Box 1571
Sydney NSW 1025
Phone: 1800 800 230
Fax: (02) 8249 3885
www.latitudefinancial.com.au/insurance

How to help us process your claim

Checklist

Before submitting your claim form, make sure you can tick **all** the boxes below:

Illness or Injury claims - documents required ✓

Section A: Statement of claimant (you) – all questions answered. ☐

Section B: Statement of employer – completed and signed by your employer. ☐

Section C: Medical certificate - completed, signed, dated and stamped by your usual treating doctor OR a copy of a hospital Discharge Certificate is supplied (for accidents only) OR your initial Workers Compensation Medical Certificate is supplied. ☐

Privacy consent and declaration - read, signed and dated by you. This is on the last page of this claim form. It's important that we have your signature here so we can start processing your claim straight away. ☐

Authorised Third Party - Complete relevant section on page 6 if you wish to give authority to **another person** to obtain updates on your claim.

Without the above information we will be unable to process your claim.
This could delay any payment to your account that you may be entitled to.

If you are having any difficulties completing this claim form, please contact our Customer Service Centre on **1800 800 230.**

Latitude
Financial Services

Hallmark General Insurance Company Ltd. ABN 82 008 477 647.
81-3576 (Rev 04/16)

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What needs to be filled out?

Section A – to be completed by claimant (you)

Section B – to be completed and signed by your employer

Section C – to be completed by your usual treating doctor

Privacy consent and declaration - to be read, signed and dated by you

Section A: Statement of claimant (you)

Who needs to fill this out?
All questions need to be answered by you

Loan/card account or Insurance policy number: _____

First name: _____ Surname: _____

Date of birth: _ _ /_ _ /_ _ _ _ Phone: (H)_____ (M)_____

Address:

Unit/house number: _____ Street name: _____

Suburb: _____ State: _____ Postcode: _____

Medical condition that has stopped you from working? _____

Have you suffered from this condition previously? Yes ☐ No ☐ If Yes, provide details: _____

_____

Date of injury/illness: _ _ /_ _ /_ _ _ _ Last day worked: _ _ /_ _ /_ _ _ _

Full details of ALL doctors you have consulted over the past five years:

Year	Doctor's name	Address	Reason
e.g. 2010 - 2015	e.g. Doctor Smith	e.g. 1-2 Smith Street Sydney	e.g. Knee Injury

Please attach details of additional doctors if applicable.

Are you receiving, or do you expect to receive any income/benefits from Workers Compensation? Yes ☐ No ☐

If yes, please provide details:

Name of insurance company: _____ Claim number: _____

Insurance company address: _____

Phone: _____ Fax: _____

Important notice: This needs to be completed in full by you. If you require any assistance in completing this claim form please contact us toll free on **1800 800 230.**

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Section B: Employer certificate

Who needs to fill this out?
To be completed by your employer. If you are self-employed, you can fill this out yourself

Employee name: _____

Name of company: _____

Address: _____

Telephone number: _____

Employment Status

Full time ☐ Casual ☐ Seasonal ☐ Part time ☐ Self-employed ☐

Occupation at time of injury or illness: _____

Average number of hours worked per week: _____ Date of hire: _ _ /_ _ /_ _ _ _ Last day worked: _ _ /_ _ /_ _ _ _

Provide full details of the employee's usual duties: _____

_____

Reason for stopping work? _____

Has the employee returned to work? Yes ☐ No ☐ *If yes, please give date:* _ _ /_ _ /_ _ _ _

Has the employee been terminated? Yes ☐ No ☐ *If yes, please give date:* _ _ /_ _ /_ _ _ _

If the employee has not returned to work, when do you expect him/her to return to:

a) partial duties: _ _ /_ _ /_ _ _ _

b) full duties: _ _ /_ _ /_ _ _ _

Is the employee's disablement as a result of an injury? Yes ☐ No ☐

Did the injury occur on the business premises, or during work hours? Yes ☐ No ☐

Is the employee in receipt of, or entitled to, Workers Compensation benefits? Yes ☐ No ☐

If yes, please provide details:

Name of insurance company: _____ Claim number: _____

Employer's signature:

Signed: _____ Date: _ _ /_ _ /_ _ _ _

Title: _____ ABN number: _____

Important notice: This needs to be completed in full by your **employer**. If you require any assistance in completing this claim form please contact us toll free on **1800 800 230.**

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Section C: Medical certificate

Who needs to fill this out?
To be completed, signed, dated and stamped by your usual treating doctor

Accident Only: We will also accept a copy of your hospital Discharge Certificate OR your initial Workers Compensation Medical Certificate.

Patient's name: _____ Date of birth: _ _ /_ _ /_ _ _ _

Are you the patient's usual medical practitioner? Yes ☐ No ☐

The date the patient first consulted your Practice for **any** condition: Date: _ _ /_ _ /_ _ _ _

What is the primary condition restricting the patient returning to work? _____

When did the patient first consult you for this condition? Date: _ _ /_ _ /_ _ _ _

Is this diagnosis defined as any of the following?

Heart attack ☐ Major organ transplant ☐ Cancer ☐

Kidney failure ☐ Coronary arterydisease requiring surgery ☐ Stroke ☐

Date the patient was first noted to suffer symptoms of, or receive treatment for, the condition: Date: _ _ /_ _ /_ _ _ _

Has the patient suffered from the same or similar condition or conditions previously? Yes ☐ No ☐

If yes, please provide initial consultation date: _ _ /_ _ /_ _ _ _ *If yes, what treatment was received?* _____

_____

Describe below any other conditions that are preventing the customer from working

Condition: _____ Date diagnosed: _ _ /_ _ /_ _ _ _

Treatment received: _____

Is the patient's diagnosis the direct result of an accident? Yes ☐ No ☐

If yes, please provide details of the accident: _____

If hospitalised, please advise the following:

Hospital: _____

From: _ _ /_ _ /_ _ _ _ To: _ _ /_ _ /_ _ _ _

Have you referred the patient to a specialist? Yes ☐ No ☐

If yes, please provide details: _____

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Who needs to fill this out?
To be completed, signed, dated and stamped by your usual treating doctor

Doctor's Statement

To the best of my knowledge, the patient has been entirely prevented from engaging in all the duties of an occupation for which he/she is reasonably suited by education, training or experience.

From: _ _ /_ _ /_ _ _ _ To: _ _ /_ _ /_ _ _ _

Average number of hours worked per week: _____ Last day worked: _ _ /_ _ /_ _ _ _

In my opinion the claimant's prognosis is: _____

I anticipate that he/she will return to work: _ _ /_ _ /_ _ _ _

Please provide further details if necessary: _____

Name: _____ Provider number: _____

Address: _____ Postcode: _____

Phone: _____ Fax: _____

Signature of medical practitioner: _____ Date: _ _ /_ _ /_ _ _ _

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Declaration & Privacy Consent (to be signed and dated by you)

1. I declare that the information supplied by me on this form is in every respect 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.
2. I hereby authorise my employer, their Workers Compensation insurer, my insurers or any hospital or medical practitioners who have treated me to provide Hallmark General Insurance Company Ltd. (Hallmark) with any information it may request regarding any illness, injury, medical history, treatment or copies of medical, hospital or employment records. A photocopy of this authorisation shall be considered as effective and valid as the original.
3. I authorise my employer and/or their Workers Compensation insurer to provide Hallmark with information relating to my employment including but not limited to my employment history, payroll information, employment records and termination.
4. I agree to Hallmark collecting my **sensitive information** (particularly health information), for the purpose of considering this claim. I understand that further information regarding how Hallmark collects, uses, discloses and stores my personal information is contained in the Important Privacy Notice and the Privacy Policy (*www.latitudefinancial.com.au/privacy*).

Name: _____

Current address: _____

Signed: _____ Date: _ _ /_ _ /_ _ _ _

Authorised Third Party (ATP)

By completing this section, you authorise Hallmark to disclose and discuss information relating to claims on your policy to the person nominated below. We will only provide information to the ATP on: claim approval, claim decline decision (not reasoning behind decision), claim wait periods, any claim information requested and/or payment amounts and schedule of payments.

You must ensure the ATP is aware of our Privacy Policy and agrees to their personal information being collected, used and disclosed accordingly.

Your personal details.

Name: _____

Signed by: _____ Date: _ _ /_ _ /_ _ _ _

Your authorised person's details.

Name: _____

Address: _____

Date of birth: _ _ /_ _ /_ _ _ _ Relationship to you: _____

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