VOLUNTARY WORKERS CLAIM FORM

point INSURANCE

CLAIM FORM INSTRUCTIONS

To avoid any delays with the processing of your claim, please ensure that all sections are fully completed and that all supporting documentation (e.g. x-ray/CT and/or MRI reports, medical expenses, hospital discharge and/or admission summaries etc) are provided on submission of the claim.

There are 4 sections to this claim form and all sections must be completed, as follows:

Section 1: **CLAIMANT CERTIFICATION** is to be completed by the person making the claim (i.e. the injured person).

Section 2: **FINANCIAL CERTIFICATION** is to be completed by the person making the claim if you are claiming for loss of income benefits.

If you are **self-employed**, complete Page 6 and follow the instructions at the top of the page about the importance of supplying appropriate financial documentation.
If you are an **employed** individual, please complete the top section of Page 6 and have your employer complete Page 7. Follow the instructions at the top of the page about supplying appropriate financial documentation.

Section 3: **MEDICAL CERTIFICATION** is to be completed by the registered medical practitioner who is/or has been involved in treating the person making the claim. Please note that any fee incurred for the completion of this part of the form is the responsibility of the person making the claim.

Section 4: **INSURED CERTIFICATION** is to be completed by the Policy Holder.

The completion of this form is used to initiate a claim. If your claim is accepted and you are eligible for loss of income benefits, the insurer may require you and/ or your treating medical practitioner to complete Progress Claim Forms whilst you are unable to return to work.

It is important to note that the issuance of this form is not an admission of liability by Point Underwriting Agency Pty Ltd.

Important note regarding claims for medical expenses Please note the policy does not provide cover for any account that is fully or partially covered by Medicare. The reason for this is that the National Health Act 1953 does not permit reimbursement of these expenses.

Please send the completed form and associated documentation to:

Point Underwriting Agency
Post: PO Box 744, Manly NSW 1655
Email: enquiries@pointinsurance.com.au
Phone: 02 9970 7378 or Toll Free on 1300 362 766
Fax: 02 9970 7290

SECTION 1 – CLAIMANT CERTIFICATION

Policy No

Name of Policy Holder

1.1 TYPE OF CLAIM

Which benefit(s) are you claiming for?

☐ Non-Medicare Medical Expenses ☐ Loss of Income ☐ Other

1.2 YOUR DETAILS

Title

First Name

Surname

Date of Birth / /

Female ☐ Male ☐

Medicare Number

Residential Address

Suburb/Town

State

Postcode

Mobile Number

Alternate Number ( )

Occupation

Email

Do you require an interpreter? No ☐ Yes ☐ If yes, please nominate your preferred language

1.3 ELECTRONIC FUNDS TRANSFER (EFT) DETAILS FOR CLAIM PAYMENTS

Important: Should your claim be accepted & benefits are payable, we will require your account details. Please be sure to complete the following section so that payments can be processed without delay.

Account Name:

BSB Number (6-digit number):

Name of Bank/Credit Union:

Account Number:

I authorise Point Underwriting Agency Pty Ltd to directly credit claim benefits to my account as noted above.

Signature of Claimant authorising EFT benefits:

Date: / /

1.4 INJURY DETAILS

1. What is the injury you sustained?

2. Which part/s of your body were injured?

3. How did the injury occur?

4. When did the injury occur? Date ☐☐ / ☐☐ / ☐☐☐☐ Time ☐☐ : ☐☐ ☐ am ☐ pm

5. Where did the injury occur?
   Address

6. Were you travelling to or from the place of voluntary work at the time of the injury?
   No ☐ Yes ☐

7. What activity were you actually engaged in at the time you were injured?

8. Were you using any electrical equipment / machinery at the time of the accident?
   No ☐ Yes ☐ If yes, please provide details below:

9. Please provide the name and contact details of any witness to your accident:
   Name
   Contact Number
   Residential Address

10. Have you made a claim, or are you entitled to claim, any benefits with another Insurer (e.g. CTP, Income Protection etc) for this injury?
    No ☐ Yes ☐ If yes, please provide details below:
    Claim made on (date) ☐☐ / ☐☐ / ☐☐☐☐
    Claim made against (organisation)
    Claim number
    Claim outcome (e.g. accepted, declined, under investigation)
    Type of Cover (e.g. CTP, Income Protection etc)

11. Have you ever previously sustained an injury to the part of your body for which you are now making this claim?
    No ☐ Yes ☐ If yes, please provide details below:
    Nature of Injury
    On (date of injury) ☐☐ / ☐☐ / ☐☐☐☐
    Name of Treating Doctor
    Address of Practice

Continue on Page 4

1.5 MEDICAL DETAILS

1. Who is your usual treating doctor?

Doctor's Name

Telephone Number
( )

Full address of practice

Suburb/Town

State

How long have you been seeing this doctor? Days Months Years

2. When did you first see a doctor for the injury? Date / /

Was the doctor you first saw your usual treating doctor?

Yes No If no, please provide the following details:

Doctor's Name

Telephone Number
( )

Full address of practice

Suburb/Town

State

How long have you been seeing this doctor? Days Months Years

3. Were you admitted to Hospital?

No Yes If admitted, which hospital were you admitted to? (please attach a copy of the hospital admission and/or discharge summary)

Hospital

Date of Admission / / Time of Admission : am pm

Date of Discharge / /

4. Have you been referred to a specialist?

No Yes Please provide the names and addresses of specialists you have been referred to.

Specialist Name

Speciality

Address

Suburb/Town

State

Telephone Number
( )

5. Have you seen this specialist before?

No Yes If yes, please provide date of previous consultation: Date / /

Reasons for previous consultation:

6. What tests have you undergone (for example CT scan, MRI, blood tests) and when? Please attach copies of any reports.

Date	Test

7. What medical treatment (including medication and therapies) are you currently receiving and how frequently?

1.6 HEALTH INSURANCE DETAILS

1. Do you have private health cover? No ☐ Yes ☐ If yes, please provide details below:

Name of Health Insurer: Membership Number:

2. Have you made any claim for this injury with your private health fund?

No ☐ If no, why not?

Yes ☐ If yes, please provide claim number(s):

1.7 CLAIM FOR MEDICAL EXPENSES

Please complete this section if you would like to claim for reimbursement of Non-Medicare Medical Expenses. Proof of the expenses claimed (i.e. receipts) will also need to be provided in order for us to consider the expenses listed below. If you have also lodged a claim for the same expense with your health insurance provider, we will need a statement from your health insurer outlining the benefit paid. If you have not made a claim with your private health insurer, you must do this before submitting any medical expenses for consideration of reimbursement with our office.

Date	Treatment	Provider	Cost	Amount Paid by Health Insurer	Account Paid (Yes/No)

Continue on Page 6

1.8 DECLARATION AND INFORMATION AUTHORITIES

I understand that Point Underwriting Agency Pty Ltd (ABN 53 605 479 070, AFS License No. 477471) may need to access, collect and disclose information about me in order to be able to assess my claim for benefits.

In order to do so, I (insert your full name here)

hereby agree that I have read, understood and agree to the collection, use and disclosure of my personal information by Point Underwriting Agency Pty Ltd as outlined in the Privacy Notice below.

In addition and without limiting the above, I authorise Point Underwriting Agency Pty Ltd to collect and disclose any information about me from and to any organisation or person including the following (which includes their current and former capacities and any organisation or person that may replace them): Medicare, any insurance or health insurance company, other insurance intermediaries, Centrelink, any hospital, physician, medical practice, medical services provider, medical therapy provider, employer, investigators, assessors and loss adjustors, other parties we may be able to claim or recover against, insurance reference bureau, financial institutions including banks, the Australian Taxation Office and my accountant.

In providing or obtaining information about me, I understand that Point Underwriting Agency Pty Ltd will use that information in the assessment of my claim, and that if I do not provide or permit access to this information my claim may not be able to be assessed.

This consent to access, collect and disclose my personal information remains valid unless I revoke or alter it by giving Point Underwriting Agency Pty Ltd notice in writing and I agree that a photocopy of this authority is to be accepted and shall have the effect of an original.

I solemnly and sincerely declare that the information provided in this claim form and any attachments which I have provided, is true, correct and complete in every detail. I agree that if I have made any misrepresentations, false or fraudulent statements, or have concealed information of a material nature relevant to the assessment of my claim, that subject to law, the policy may be cancelled and / or Point Underwriting Agency Pty Ltd may refuse to pay a claim.

Signature

Date

☐☐ / ☐☐ / ☐☐☐☐

To be completed if another person has signed on behalf of the person making the claim:

Name of person who signed on behalf of the claimant

Relationship to the claimant

Reason why the claimant could not sign

1.9 PRIVACY NOTICE

Point Underwriting Agency Pty Ltd (Point) collects, uses and retains your personal information only in accordance with Australia's National Privacy Principals.

A copy of our Privacy Policy is available on our website at www.pointinsurance.com.au or by contacting our customer relations team on 1300 362 766.

Your personal information will be used by Point, or any third party that Point provides the information to, for the purposes of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:

- Any information provided in relation to your claim;
- Any information that is health information or sensitive information, including, without limitation, your medical history, any treatment received by you and any medication taken or prescribed for you or your Health Insurance Claims history, including Medicare;
- Any information relating to any relevant insurance policy, including terms and conditions and claims history;
- Details of your employment including position, period of employment, remuneration, hours worked and duties performed;
- Any other information in relation to your income, assets, liabilities and solvency; and
- Any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To process your claim, Point may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (e.g. Centrelink or the Australian Tax Office), your doctor or other health service provider, your employers (past and present) and / or your accountant.

Point may disclose your personal information, including health and sensitive information, to third parties, including contractors and contracted service providers engaged by us to deliver our services (such as assessors), other insurers, our reinsurers, and government agencies including the police (where we are compelled to by law). These third parties may be located outside Australia. Point may also disclose your personal information to witnesses in relation to your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our office on 1300 362 766 or email enquiries@pointinsurance.com.au.

SECTION 2 – FINANCIAL CERTIFICATION

Please complete this section if you would like to claim for loss of income benefits.

1. Did the injury cause you to cease work completely?

   Yes ☐ If yes, on what date did you completely cease work? Date ☐☐ / ☐☐ / ☐☐☐☐

   No ☐ If no, when are you expecting to cease work? Date ☐☐ / ☐☐ / ☐☐☐☐

2. Have you since returned to work?

   Yes ☐ If yes, when? Date ☐☐ / ☐☐ / ☐☐☐☐ Full Time ☐ Part Time ☐

   No ☐ If no, when do you expect you will be able to return to work? Date ☐☐ / ☐☐ / ☐☐☐☐

2.1 SELF EMPLOYED

IMPORTANT INSTRUCTIONS

If you are **SELF-EMPLOYED** you must complete this page. You must provide a copy of your entire Individual Taxation Return & Notice of Assessment (NOA) for the financial year immediately prior to your ceasing work due to your Injury and if you are a Company/Partnership please also provide a copy of your entire Business Taxation Return. If you operate a Trust as part of your business structure you must also include a full copy of the entire Trust Taxation Return.

1. What is your usual occupation?

2. How long have you been engaged in your current occupation?

3. What is your Business Structure (e.g. sole trader, partnership, trust, company)?

4. Business/Company name ABN ☐☐☐☐☐☐☐☐☐☐☐

5. Business Address

   Suburb/Town State Postcode ☐☐☐☐

6. Please provide your Accountant's details:

   Accountant's Name

   Business Address

   Contact Number ☐☐☐☐☐☐☐☐☐☐ Email

   Did you/your Accountant complete and lodge a taxation return for the last financial year?

   No ☐ Yes ☐

SECTION 2 – FINANCIAL CERTIFICATION

IMPORTANT INSTRUCTIONS

If you are an **EMPLOYEE** your employer must complete this page and you must complete the top of Page 6. If you are an **EMPLOYEE**, please provide a copy of your pay slips for the 12 month period immediately prior to you ceasing work.

2.2 EMPLOYEE DETAILS

I hereby certify that (name of Claimant):

has been engaged/employed by the company/business since: / / In the position of:

1. Did the person ENTIRELY CEASE WORK in their employed position?

   No ☐ Yes ☐ If yes, on what date did they completely cease work? Date / /

2. Did the person ONLY PARTIALLY CEASE WORK in their employed position?

   No ☐ Yes ☐ If yes, from when? Date / /

3. Has the Claimant returned to work?

   No ☐ Yes ☐ If yes, please advise from when and at what capacity:

   Date / / Full Time ☐ Part Time ☐

4. During the period of incapacity did your employee receive any of the following:

Paid sick leave ☐ from / / to / / in the amount of $ gross p/w

Workers comp. ☐ from / / to / / in the amount of $ gross p/w

Employee's sick leave entitlement as of the date of injury/illness Days

Gross Weekly Earnings averaged over the 12 months prior to disablement $ per week

2.3 EMPLOYER DETAILS

Name of person completing this form

Position (e.g. manager, owner, HR)

Company /Business Name

Company / Business Address

Suburb/Town

State

Contact Number

Email

Signature

Date / /

SECTION 3 – MEDICAL CERTIFICATION

This part of the claim form must be completed by a registered doctor. Please note that any fee incurred for the completion of this form is the responsibility of the patient.

SECTION 3.1 PATIENT DETAILS

First Name

Surname

Date of Birth ☐☐ / ☐☐ / ☐☐☐☐

Patient's Occupation

1. How long has the patient been known at your practice? ☐☐ Days ☐☐ Months ☐☐ Years
2. Are you the patient's primary treating physician at your practice?

   Yes ☐ No ☐ If no, please provide details of the physician who is:

3. What is the medical diagnosis that is disabling the patient?
4. Is the condition an/a:

		Date of Injury	Cause of Injury	Diagnosis Date
Injury	☐	☐☐ / ☐☐ / ☐☐☐☐		☐☐ / ☐☐ / ☐☐☐☐
		Date of onset/first symptoms	**Cause of Sickness**	**Diagnosis Date**
Sickness	☐	☐☐ / ☐☐ / ☐☐☐☐		☐☐ / ☐☐ / ☐☐☐☐

   Nature of symptoms

5. When did the patient first consult you in relation to this medical condition? Date ☐☐ / ☐☐ / ☐☐☐☐
6. Is there any previous history of this or of a similar condition?

   No ☐ Yes ☐ If yes, please provide full details of the previous history of the injury or sickness:

7. On what date was the patient first certified unfit for work? Date ☐☐ / ☐☐ / ☐☐☐☐
8. When considering the patient's occupational duties, do they remain disabled from work?

   No ☐ Date certified fit to return to work: Date ☐☐ / ☐☐ / ☐☐☐☐

   Yes ☐ Please provide certification dates:

   Totally Disabled from: Date ☐☐ / ☐☐ / ☐☐☐☐ To Date ☐☐ / ☐☐ / ☐☐☐☐

   Partially Disabled from: Date ☐☐ / ☐☐ / ☐☐☐☐ To Date ☐☐ / ☐☐ / ☐☐☐☐
9. Please list details of any tests, x-rays, scans, pathology etc conducted to confirm the diagnosis. Please also provide copies of any reports.

Test	Date Performed	Conducted By	Result

SECTION 3 – MEDICAL CERTIFICATION

10. What is the patient's current medical treatment regime? If the patient requires/will require treatment(s) from a physiotherapist, chiropractor, rehabilitation specialist etc, please specify the type of treatment and approximate number of treatments required.

11. Have there been or will there be any surgical procedure to be performed?

No ☐ Yes ☐ If yes, please provide details below:

Type of surgical procedure required/performed?

Date of surgery scheduled/was conducted: Date ☐☐ / ☐☐ / ☐☐☐☐

12. Are there any concurrent conditions which are affecting the patient's ability to return to work?

No ☐ Yes ☐ Please state what the concurrent condition is and to what degree it prevents/restricts the patient returning to their occupation

13. Are you providing information in respect of this patient to any other insurer?

No ☐ Yes ☐ If so, which insurer?

SECTION 3.2 DOCTOR'S DECLARATION

We advise that any information received by or requested from you by Point Underwriting Agency Pty Ltd is handled in accordance with the relevant privacy legislation. Should you wish to obtain a copy of our Privacy Policy, it is available upon request or you can visit our website at www.pointinsurance.com.au.

The information provided in this medical certificate is a truthful, comprehensive and accurate account of the patient's medical condition, medical history and level of disability.

Signature

Date ☐☐ / ☐☐ / ☐☐☐☐

Name

Qualifications

Practice Address

Suburb/Town

State

Contact Number ☐☐☐☐☐☐☐☐☐☐

Fax Number (☐☐)☐☐☐☐☐☐☐☐

Email

SECTION 4 – INSURED CERTIFICATION

This section of the claim form is required to be completed by the Voluntary Workers policy holder.

SECTION 4.1 DETAILS OF INSURED PERSON

Full Name

Residential Address

Construction / Renovation Site Address

Contact Number

Email

SECTION 4.2 INCIDENT NOTIFICATION

Name of the Injured Person

Date of Injury: / /

Location of Injury:

Nature of Injury:

Please describe the circumstances as to how the injury occurred:

SECTION 4.3 INSURED DECLARATION

We advise that any information received by or requested from you by Point Underwriting Agency Pty Ltd is handled in accordance with the relevant privacy legislation. Should you wish to obtain a copy of our Privacy Policy, it is available upon request or you can visit our website at www.pointinsurance.com.au.

I confirm that the Claimant was a nominated volunteer at the time of the accident. Furthermore, the information contained in this statement is true and correct and has been completed to the best of my knowledge.

Name of Insured:

Signature

Date / /