



ace asia pacific

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Insurance Claim Form

CLAIM NUMBER
Office Use Only

- 1. Please complete the Policy Details Section and any of the following sections which relate to your claim.
2. Please ensure that this form is signed and that all questions are answered fully
3. To avoid delay in processing your claim, please ensure that all necessary documentation specified in the section relevant to your claim is sent with this form.
4. Claims may be subject to an excess as described in your Policy.
5. Please send this form and all documentation to: The Accident & Health Claims Department, ACE Insurance Limited, GPO Box 4065, Sydney, NSW 1008.

A. POLICY AND CLAIMANT DETAILS COMPLETE FOR ALL CLAIMS

POLICYHOLDER: Claimant [ ] Other [ ] -Given Name [Mr/Mrs/Miss/Ms]
Card Account Number (if applicable)
Schedule Number (if applicable)
Policy / Certificate Number
Expiry Date / /
Name of Broker who provided the cover
Full Name: Surname, First Names
Home Address: State, Postcode
Postal Address (if different from above): State, Postcode
Telephone No.: Private: ( ), Business: ( )
Employers Name
Occupation
Usual Duties: Date of Birth / /
What are your gross weekly earnings:
Who are you claiming for: Self [ ] Spouse [ ] Child [ ] - Give Name
What are you claiming for? (e.g. Temporary Total Disablement)

GST INFORMATION

- (a) What is your Australian Business Number (ABN)?
(b) Are you registered for GST Purposes? Yes [ ] No [ ]
(c) Have you claimed or are you entitled to claim an Input Tax Credit (ITC) on your Business Activity Statement to the Australian Taxation Office in respect to the GST paid on the insurance policy under which this claim is being made? Yes [ ] No [ ]
(d) IF YES, what percentage of the GST did you claim or are you entitled to claim? % (if the GST paid and your ITC entitlement are the same amount, the answer to this question is 100%)

B. CLAIMS FOR INJURY / ILLNESS / DEATH

What is the injury or illness?
If injury, how exactly did it occur? i.e. playing sport, etc.
When did the injury occur, or the illness begin or first manifest itself or when was it first diagnosed? / /
Did the injury or illness cause you to stop work? No [ ] Yes [ ] -when? / /
Have you returned to work full-time? No [ ] Yes [ ] -when? / /
OR
Have you returned to work part-time? No [ ] Yes [ ] -if Yes, what hours and duties are you working?
Days [ ] Hours [ ]
Duties

**Who is your usual family doctor?**

Name

Address

Telephone Number


**When did you first get treatment from a medical practitioner for this condition?**

Doctor's Name

Address

Telephone Number

When did you first see the medical practitioner?

/ /

**Have you consulted any other medical practitioner for this condition?** No  Yes  – give details

Doctor's Name

Address

Telephone Number

Period

from / / to / /

**Did you go to hospital?** No  Yes  – give details

Hospital Name

Address

Period

from / / to / /

**During the 24 hours before the injury, did you drink any alcohol or take any drugs?** No  Yes  – give details

State types & quantities

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**Have you ever had this or a similar condition in the past?** No  Yes  – give details

Dates, treatment & names & address of person who treated you


**What other significant medical or surgical treatment have you received in the past 5 years?**

Give dates, nature of the condition & names & addresses of persons who treated you


**Are you affected by any other long term or chronic disability?** No  Yes  – give details

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**C. CLAIMS FOR ADDITIONAL BENEFITS FOR INJURY OR ILLNESS****NOT ALL POLICIES PROVIDE THESE BENEFITS. PLEASE ONLY COMPLETE IF APPLICABLE.**

Are you claiming for:-

- **homecare or income replacement after major surgery for cancer** Yes
- **childminding or income replacement after a child's accident** Yes
- **home tuition fees after a child's accident** Yes
- **medical expenses not covered by Medicare** Yes
- **damage to personal property** Yes

Give details, specifying each item

ITEM	AMOUNT

**PLEASE ATTACH ACCOUNTS OR OTHER EVIDENCE OF THE EXPENSES YOU HAVE INCURRED OR RECEIPTS FOR DAMAGED PROPERTY.****D. OTHER INSURANCE / BENEFITS****Are you claiming insurance or compensation from any other insurance company?** eg. Workers Compensation, Traffic Accident Commission, sports body or any income replacement.No  Yes  – give details below

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Name of organisation

Name of Insurer &amp; Telephone No.

Type of cover

Amount claimed

per week

Do you have private health insurance?

No  Yes  – give details

Do you have ambulance cover?

No  Yes **E. DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS****I declare that**

- the information on this form and any documents attached to it, is correct and complete
- I have not withheld any information that could affect this claim
- I am the policyholder or a nominated beneficiary of the insured person covered by this policy

**I authorise**

- any hospital, physician or other person who has attended me to furnish ACE Insurance Limited or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records. I agree that a photostat copy of this authorisation shall be considered as effective as the original.
- ACE Insurance Limited to give to, or obtain from, other insurers or insurance reference bureau any information about this claim.

**Your signature****Name – print****Date****PLEASE GET THE DOCTOR TO COMPLETE THE ATTACHED STATEMENT AND SEND IT TO US. THE DOCTOR MAY ASK YOU TO PAY A FEE.****IF THE CLAIM IS FOR DENTAL EXPENSES, PLEASE HAVE THE TREATING DENTIST PROVIDE A CERTIFICATE CLEARLY SHOWING ALL TREATMENT, HEALTH FUND BENEFIT ITEMS AND COSTS.**

# Medical Practitioner's Statement to Company

THE POLICYHOLDER IS RESPONSIBLE FOR ANY FEE FOR THIS STATEMENT  
THIS FORM SHOULD BE COMPLETED AND RETURNED TO ACE PROMPTLY

Patient's Full Name

Date of Birth

 /  / 

Height

cms

Weight

kgs

**Diagnosis** (if fracture or dislocation, describe nature and location i.e.: **Simple, Compound**)


If available please provide a copy of X-ray report

Is this condition an injury  or an illness

**Does the patient have any other injury or illness that is contributing to the condition?**

No

Yes  – give details

**Is condition due to injury or sickness arising out of the patient's employment?**

No

Yes  – give details

**Was the disability, sports related?**

No

Yes  – give details

**Date of onset/first symptoms**

 /  / 

**When did the patient first consult you for this condition?**

 /  / 

**Has the patient ever had the same or similar condition?**

No

Yes  – give details

**How long have you been the patient's usual doctor/medical practice?**

 yrs

**Name of patient's usual doctor/medical practice**

**Has the patient had surgery or is it anticipated?**

No

Yes  – give details

**Date performed or anticipated**

 /  / 

**Give name of hospital?**

**Did you provide other medical services (including pathology) to the patient?**

No

Yes  – itemise, give details

Date / /	
Date / /	

**Was the patient referred by you or to you?**

No

Yes  – give details

Please provide name and address of referring doctor

Name

Address

Date of referral

/ /

**Is the patient still disabled?**

No  – when did the patient return to work?

/ /

Yes  – how long will the patient be:

- totally disabled (unable to perform any part of their occupation)

from / / to / /

- partially disabled (unable to perform any part of their occupation)

from / / to / /

**If partially disabled, what duties could the patient perform and for how many hours a week?**

	hours per week

**Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body?**

No

Yes  – give details

Name of Company and Claim No.

Contact Name and Telephone No.

**Remarks**


**Signature of medical practitioner**

**Name – print**

**Qualifications**

**Address**

**Telephone Number**

	Date / /