



Millennium Underwriting Agencies Pty Ltd
 ABN: 38 079 194 095
 AFSL: 246721

Adelaide Office
 176 Fullarton Road Dulwich SA 5065
 PO Box 309 Kent Town SA 5071
 Phone: (08) 8291 2300
 Fax: (08) 8333 0034
 DX: 426

Sydney Office
 Level 1, 401 Pacific Highway
 Artarmon NSW 2064
 PO Box 833 Artarmon NSW 1570
 Phone: 1300 789 642
 Fax: 02 9437 9066

PERSONAL ACCIDENT & ILLNESS CLAIM FORM

Important Notes

- Please complete the claimant's section and have the medical certificate completed by the Doctor attending you.
- This form is not to be taken as an admission of liability or waiver of any rights by companies.

Client Details

Are you registered for GST purposes? Yes No

What is your ABN? _____:_____:_____:_____:_____:_____:_____:_____:_____:_____

Have you claimed, or do you intend to claim an input tax credit on the GST component of the premium applicable to this policy?
 No Yes If yes, will you be claiming and amount less than 100%? No Yes
 If yes, specify amount claimed? _____%

Are you entitled to claim an input tax credit for any claimable policy benefit?
 No Yes If yes, will you be claiming and amount less than 100%? No Yes
 If yes, specify amount claimed? _____%

Agent/Broker: _____ Due Date: _____
 Policy Number: _____ Claim Number: _____

Name of Insured: _____
 Address: _____
 Contact Number: _____
 Email Address: _____

Name of Insured Person: _____
 Address: _____
 Contact Number: Private - _____ Business - _____
 Date of Birth: ____/____/____ Height: _____ Weight: _____ Sex: _____
 Occupation: _____
 Describe usual duties of Occupation: _____

Claim Details

Give full description of injury or illness from which you are now suffering. In an injury, tell when, where and how it happened

Illness: _____

Injury: _____

Have you ever had this or a similar condition in the past? Yes No

If yes, state the nature of the conditions, dates of treatment and names and addresses of treating doctors, hospitals and clinics.

Dates: _____

Conditions: _____

Treated By: _____

Address: _____

Give exact details when illness began, or injury occurred: Date: _____ Time: _____

When did you first consult a physician for this condition? Date: _____ Time: _____

When did you become totally disabled (unable to work)? Date: _____ Time: _____

When were you able to again perform part of your occupational duties? Date: _____ Time: _____

If still totally disabled, when do you expect your disability to terminate? Date: _____ Time: _____

Please supply the names, address and telephone numbers of all physicians you have consulted?

What other medical treatment have you received in the past five years?

Please list full details of all illnesses or injuries and the doctors or physicians consulted.

Who is your usual family doctor?

Have you ever lodged a personal accident or illness claim before? Yes No

If so, please provide full details

Are you currently suffering from any other illness or condition (other than the subject of this claim)? Yes No

If so, please provide full details

Are you making any other insurance or compensation claim as a result of accident or illness? Yes No

If so, please provide full details

Declaration and Authorisation by Claimant

I hereby authorise any hospital, physician or other person who has attended me, or any employer, to furnish Millennium Underwriting Agencies Pty Ltd or its representatives with any and all information with respect to any illness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical records and copies of all records of employers including verification of earnings.

I agree that a Photostat copy of this authorization shall be considered as effective and valid as the original.

I also authorise that Millennium Underwriting Agencies Pty Ltd to give to and obtain from any other insurers, any insurance reference bureaus and credit reporting agencies, any information relating to my history as well as insurance claims information obtained during the course of this contract.

I declare that the preceding statements and information are to the best of my knowledge and belief, true in every respect.

Signature

____/____/_____
Date

If Injury

When did the patient suffer the injury?

Date: _____ Time: _____

What did the patient tell you were the circumstances surrounding the injury?

If Illness

When was the illness first contracted?

Date: _____ Time: _____

When did the symptoms become evident?

Date: _____ Time: _____

Degree of Disability

When was the patient obliged to cease work?

Date: _____ Time: _____

If the patient is still disabled, when will the patient be able to resume:

- one or more of the material tasks of his/her occupation?
- all of the tasks of his/her occupation?

Date: _____

Date: _____

If the patient has recovered, when will the patient be able to resume:

- one or more of the material tasks of his/her occupation?
- all of the tasks of his/her occupation?

Date: _____

Date: _____

A FINAL MEDICAL CERTIFICATE IS REQUIRED SHOWING THE ACTUAL DATE THE PATIENT HAS RESUMED WORK.

Treatment of Present Condition

When were you first consulted?

Date: _____

When were you last consulted?

Date: _____

How often has the patient consulted you?

_____ times

Was the patient confined to hospital?

Yes No

If yes, please provide details:

Name of Hospital: _____

Address: _____

Period of Confinement: From: _____ To: _____

What are current subjective symptoms? _____

Please give results of any objective findings:

X-Rays _____

Other Tests _____

Treatment of Present Condition

What surgical procedures have been performed or are being contemplated?

Is there any underlying condition affecting recovery from the current condition? Yes No

If Yes, advise nature of underlying condition and how it affects disability and recovery

Do you believe rehabilitation would benefit this patient? Yes No

Have you terminated treatment? Yes No

If yes, please advise date: _____/_____/_____

What is the current prognosis?

Are there any further remarks which may assist in assessing this condition?

Doctors Name: _____

Qualification: _____

Address: _____

Telephone No.: _____

Signature: _____

Date: _____/_____/_____