

personal accident/illness claim



Lumley General Insurance Limited, ABN 24 000 036 279, Lumley House Level 9, 309 Kent Street, Sydney 2000 Ph: (02) 9248 1111 Fax: (02) 9248 1122

1. Client Details

Claim No. Policy No. Due date (dd/mm/yyyy)

Insured's name

Address Postcode

Insured persons name

Address Postcode

Age Occupation Phone number

2. Goods and Services Tax (G.S.T.)

To ensure you do not incur any unnecessary GST liabilities on this claim please advise your:

(a) Australian Business Number (ABN), if applicable

(b) entitlement to an Input Tax Credit in respect of:

(i) Insurance premium % and (ii) the property which is the subject of this claim %

3. Accident Details

Particulars of accident:

Date (dd/mm/yyyy) Time

Where did the accident happen?

State clearly how the accident occurred

Nature of injury sustained

Names and addresses of witnesses

Lumley General Insurance Limited

NSW	Lumley House, Level 9, 309 Kent Street, Sydney 2000 Suite 19, 50 Glebe Road, The Junction 2291	Phone (02) 9248 1111 Phone (02) 4925 7500	Fax (02) 9248 1122 Fax (02) 4940 0295
VIC	Level 3, 99 King Street, Melbourne 3000	Phone (03) 8627 4333	Fax (03) 8627 4312
ACT	Level 4, Perpetual Building, 10 Rudd Street, Canberra City 2601	Phone (02) 6279 0333	Fax (02) 6279 0330
TAS	27 Paterson Street, Launceston 7250	Phone (03) 6345 4700	Fax (03) 6345 4711
SA	465 Pulteney Street, Adelaide 5000	Phone (08) 8228 1700	Fax (08) 8228 1777
WA	50 St George's Terrace, Perth 6000	Phone (08) 9220 8222	Fax (08) 9220 8251
QLD	Level 2, 99 Melbourne Street, South Brisbane 4101 Level 5, Northtown Tower, Flinders Mall, Townsville 4810	Phone (07) 3307 4800 Phone (07) 4722 6000	Fax (07) 3307 4899 Fax (07) 4724 4398
NT	Level 2, Beagle House, 38 Mitchell Street, Darwin 0800	Phone (08) 8946 4600	Fax (08) 8946 4666

4. Illness Details

State nature of illness

Date first contracted (dd/mm/yyyy)

5. Medical Attention

Who first treated you for the injury or illness?

When (dd/mm/yyyy)

Is this person your usual medical attendant?

No Yes

If not, please advise name and address of your usual doctor

Have you received medical treatment during the last five years?

No Yes

If so, give details

Have you, as the direct result of the illness or accident, been totally incapacitated from attending to business of any kind?

No Yes

If so, state for how long

Are you still totally incapable of attending to business of any kind?

No Yes

If now able to attend any portion of your business or occupation, state when you commenced to do so. (dd/mm/yyyy)

Have you fully resumed your usual business or occupation?

No Yes

If so, when (dd/mm/yyyy)

I hereby warrant the truth of the foregoing statement.

6. Privacy Statement

This information will be treated with confidentiality and will only be released as per the requirements of the General Insurance Information Privacy Principles. We collect and store the information for the sole purpose of maintaining your insurance details. If you require any further information, please contact your local Lumley state office.

Signature

Dated (dd/mm/yyyy)

The issue of this claim form is not an admission of liability on the part of the Company

Certificate of Medical Attendant

Name of claimant

So far as you are aware, how did the injury arise, or when did the sickness occur?

When did he/she first consult you in connection with this accident or illness? (dd/mm/yyyy)

Are you the usual medical attendant?

No Yes

If so how long have you known him/her?

Please state fully the nature of the injuries sustained, or illness
(If it is a limb or eye injured or affected state whether right or left?)

Are the symptoms from which he/she suffers due to the accident or illness alone?

No Yes

Have you any reason to suspect that the Claimant was under the influence of drink or drugs at the time of the accident?

No Yes

Is the Claimant suffering from any disease in addition to the present injuries or has he/she any physical defect?

No Yes

If so, state the nature of same, and to what extent the recovery may be affected thereby.

If the Claimant is in your opinion unable to give any attention to his/her profession or occupation, as described on the front page, or to perform any part of his/her usual duties, please state:-

Date of commencement total disablement (dd/mm/yyyy)

Final date of total disablement (dd/mm/yyyy)

In the event of the Claimant being able to give partial attention of such profession or occupation or to perform some part of his/her usual duties, please state:

Date of commencement partial disablement (dd/mm/yyyy)

Final date of partial disablement (dd/mm/yyyy)

Has the Claimant ever suffered from this or a similar complaint?

No Yes

If so, when?

Is the complaint of a chronic or recurring nature?

I CERTIFY that to the best of my belief the foregoing statements are correct.

Signature

Qualifications

Address

Date (dd/mm/yyyy)