

Describe your usual duties

Describe the injury or sickness for which you are claiming

On what date did your sickness commence, or injury occur? / /

If **injured**, what were you doing at the time?

Have you ever suffered a similar sickness or injury in the past? YES / NO

If yes, give full details:

nature of incapacity/ severity:

Period of time off work: from / / to / /

When did you first consult a doctor for the condition for which you are claiming? / / at AM / PM

When did you become totally disabled for work? / / at AM / PM

If still **totally** disabled, when do you expect to return to work? / / at AM / PM

If you have returned to work, when were you able to again perform:-

1. Part of your occupational duties? / / at AM / PM

2. All of your occupational duties? / / at AM / PM

Give details below of all attending physicians and hospitals attended.

Date of consultation/Treatment / /

Name of hospital

Name of Doctor Phone

Address/Email

Date of consultation/Treatment / /

Name of hospital

Name of Doctor Phone

Address/Email

Name of Your usual Doctor Phone

Address/Email

Have you ever lodged a Personal Accident or Sickness claim before? YES / NO

If YES, On what date? / /

What injury or illness did you suffer?

Give details of incapacity

Insurer Details : Address/Claim No/Policy

Do you have private health insurance? YES / NO

If yes, please provide Name of Health fund and Level of cover

Are you making any other insurance or compensation claim in respect of this disability? YES / NO

If so, please provide full details of cover

Please specify whether **Government Benefits / Superannuation or Life Insurance** / or other

NB: All injury claims must first be notified to ACC

ACC record number:

Section 3 Insured person: If Self Employed

Please submit documentation to validate earnings.

What are your **average** weekly earnings, net of expenses, but **before** tax? \$

Do you operate as a Limited Liability Coy? YES / NO

Do you or your Company pay ACC Levy? YES / NO

What is your Business Trading Name?

Address Phone (include area code)

What Date did you Commence Trading? / /

What is your Accountant's Name ?

Address Phone

Section 4 Employer/Paymaster to complete:

(If Insured person is a wage earner or contractor in scheme)

I hereby certify that has been unable to attend to his/her usual occupation with the Company as a result of *An injury/Injuries/Sickness suffered whilst on / /

He/She has been Incapacitated since / / and is *expected to/did resume duties on / /

His/her average weekly salary (excluding bonuses, commissions, overtime payments and other allowances) for the 12 months prior to the injury or sickness. \$ Per .Week. During the period of incapacity he/she received

Normal Pay \$ from / / to / /

Sick Pay *\$ from / / to / /

ACC Pay *\$ from / / to / /

Other (Please Specify) *

\$ from / / to / /

He/she has been employed with the Company since / /

Name of Company

Company Stamp

Name of Employer / Paymaster Phone []

Email Address

Signature Date / /

(print name and position of authority)

Section 5 - Sports Injury claim

to be completed by the Club Secretary / Treasurer.

Name of Club

Secretary / Treasurer's Name Phone []

Address/Email Address

I certify that was injured on / /

whilst playing (sport) at Grade with the club

Signature Date / /

(print name and position of authority)

Declaration- Authority & Privacy Consent

If you are signing on behalf of the Insured person please state your authority to do so and relationship. Please print your name and contact phone:

Name Phone

Position of Authority to sign – Nature of Relationship

Declaration

I/we (print name/s)

declare that the above answers and those contained in any attachments are true and note that the Insurer may rely on such answers in determining a claim. I/we have not concealed any material fact relating to this circumstance. I/we undertake to provide Chartis Insurance New Zealand Limited (Chartis) with assistance in dealing with this matter and understand that failure to co-operate with Chartis and to provide all information relevant to the circumstance may result in my/our claim being denied.

I also declare that I/we have:

(1) *No other accident of sickness insurance with any Insurance Company

OR

(2) * Accident of sickness Insurance with (print name of Insurance Company)

***Delete whichever is not applicable**

Authority:

I/we authorise any hospital, physician or other person who has attended me, or my employer or my accountant to furnish Chartis or its representatives with:

- I. copies of hospital and medical reports/notes;
- II. copies of employment records and income tax returns; to the extent that they are relevant to the claim and
- III. information pertaining to my medical history (any sickness or disease or injury, consultation, prescription or treatment).

I/we agree that a photocopy of this authorisation shall be considered as effective and valid as the original and authorise its use as such.

Privacy:

I/we consent to Chartis in accordance with the *Privacy Act 1993*:

1. collecting holding and using personal information including information by audio, photographic or video surveillance, provided for purpose of administering a claim including investigating, assessing and paying any claim made by me or on my behalf;
2. disclosing personal information submitted to another Chartis company, its staff members, the insured, other insurers and re-insurers, law enforcement agencies, investigators, lawyers, assessors, advisors and the agent of any of these, insurance broker, insurance agent or intermediary, employer for the purpose of administering my claim or providing a report.

Information is provided voluntarily however if we do not collect this information we may not be able to assess a claim. Insured persons have rights of access and correction to their personal information under the Privacy Act. Further information about this or making a privacy complaint can be obtained by emailing : Privacy.officerNZ@chartisinsurance.com

NOTE: Chartis will only seek information which in its opinion it believes to be relevant to investigation of the claim

I/we consent to Chartis assistance provider, Travel Guard, recording of all calls to the assistance service provided under the Travel Insurance for quality assurance, training and verification purposes.

Signatures/s of Insured person/s

Date

/ /

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www.chartisinsurance.co.nz

Attending Physician's Statement

This form must be completed without expense to the Insurer

Please print clearly If there is insufficient space for any answers please attach a separate sheet.

Patient's Name Age

Medical Condition

Diagnosis:

Any Complications? YES / NO

If yes give details

What are the factors causing disablement?

When did patient first receive medical attention for the above? / /

By whom? Qualifications

Dates discharged from your care / / OR What treatment is proposed ongoing?

Injury

If an injury, when did the accident occur? / /

Has injury described above resulted in any residual disability? YES / NO

If Yes please give full details and provide copies of specialist or other reports

Hospitalisation

Dates hospitalised: Admitted / /

Name and location of hospital

What Operation if any was performed?

Were there any other doctors or consultants attending? YES / NO If insufficient space please attach separate sheet

Name Speciality

Address/Email Phone

Prognosis / Extent Of Disability:

Based upon Patient's occupation of : (specify)

a. Has the patient been able to do ANY work? YES / NO

b. If so from what date? Full duties / / Restricted Duties / /

If not, when will he/she be able to work? Full duties / / Restricted Duties / /

Continued over page

Prior History

Are you the usual family doctor for this Patient?

YES / NO

Since what date?

/ /

Has patient ever had the same or a similar condition previously?

YES / NO

Date

/ /

Condition

Were you the treating physician?

YES / NO

If not please give name and contact details of other Treating Physician

Name

Phone

Address

Email

Prior Defects

Does Patient have any defects or chronic conditions?

YES / NO

If yes, when originated

/ /

Is there anything else you can tell us or recommend which would assist in our assessment or the most effective treatment?

Your name

Your Qualifications:

Phone

Email

Address

Signatures/s of Insured person/s

Date

/ /

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