Millennium

Underwriting Agencies

Millennium Underwriting Agencies Pty Ltd
ABN: 38 079 194 095 | AFSL: 246721
PO Box 309 Kent Town SA 5071
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Personal Accident & Illness Claim Form

Claims Procedure

This claim form is to be completed when Your Property has been lost, damaged, stolen or destroyed. It may be necessary for You to arrange urgent temporary repairs to protect Your Property.

It is necessary for You to complete all Sections of this claim form. Please answer all parts of the appropriate questions relevant only to the type of claim that You are lodging. If there is insufficient space provided for any information requested or to be supplied, please supply these details on a separate sheet and attach to the claim form.

Please attach (or promptly supply) where possible the original repair invoice or quotations with this completed form as well as any notices to the Police for Property lost or stolen or any Malicious Damage.

On receipt of the above We will assess and administer Your claim in accordance with Your Policy. We will also keep You informed of any other requirements should they be required and we will keep you advised on the progress on the processing of Your claim. If You have any queries on any of the information required on this form, please do not hesitate to contact Your Authorised Representative or Broker or Millennium Underwriting Agencies Pty Ltd

Privacy

Millennium Underwriting Agencies Pty Ltd respects your privacy and complies with the Privacy Act and the Australian Privacy Principles. A copy of our Privacy Policy is available at www.millennium.com.au

Complaints Procedure

If you do not agree with any decision we make in relation to the Policy, please write to us stating what you disagree with and why.

We will then resolve or attempt to resolve your complaint immediately, or we will refer the matter to our Internal Dispute Resolution Committee (IDRC). If you are not satisfied with a decision by the IDRC, the matter may be referred to an independent dispute resolution body, Financial Ombudsman Service (FOS), provided the matter falls within their jurisdiction.

Financial Ombudsman Service (FOS)
Freecall 1300 78 08 08
Post: GPO BOX 3, Melbourne Victoria 3001
Website: www.fos.org.au
Email: info@fos.org.au

The Insurance Contracts Act 1984 (as amended) requires you to provide all information which your insurer may reasonably require, and stipulates that any omission may adversely affect the cover under your Policy.

If you would like more information on your Duty of Disclosure (or any other aspect), please contact your Authorised Representative, Broker or Millennium Underwriting Agencies Pty Ltd

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

Name of Insured: | Due Date:

Agent/Broker: | Policy Number:

Address:

Contact Person: | Contact Number:

Email: | Occupation:

Name of Claimant:

Claimant Address:

Private Contact Number: | Business Contact Number:

Claimant Date of Birth: | Height:

Weight: | Gender:

Claimant Occupation:

Describe usual duties of Occupation:

Are you registered for GST purposes?: | What is your ABN?:

○ Yes ○ No

Have you claimed, or are you entitled to claim an input tax credit on the GST component of the premium applicable to this policy?:

○ Yes ○ No

If yes, will you be claiming an amount less than 100%?: | If yes, specify amount claimed (%):

○ Yes ○ No

Client Details *(continued)*

Are you entitled to claim an input tax credit for repairs or replacement of the item that has been lost or damaged?:

○ Yes ○ No

If yes, will you be claiming a tax amount less than 100%?:

○ Yes ○ No

If yes, specify tax amount claimed (%):

(1) Accident Claim Details *(if illness claim please refer to next page)*

Accident Date:

Location:

Time:

Please provide a full description of the accident and how You sustained the injury(ies):

Did the police attend the accident?:

○ Yes ○ No

If yes, please provide: Police report number:

Officers name:

Station:

Were You under the influence of drugs or alcohol at the time of the injury/accident?:

○ Yes ○ No

(1) Accident Claim Details *(continued)*

If yes, provide full details, including any readings that were taken:

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 Your 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):

If You were admitted to a hospital, or treated as an outpatient, please give details:

Name of hospital:

Date/Time admitted:

Date/Time discharged:

In patient or outpatient?:

Please provide details of all the doctors that attended to You:

Doctors Name:

Address:

Phone Number:

Treatment provided/dates:

Doctors Name:

Address:

(1) Accident Claim Details *(continued)*

Phone Number:

Treatment provided/dates:

Doctors Name:

Address:

Phone Number:

Treatment provided/dates:

Have You ever had this or a similar injury in the past?:

○ Yes ○ No

If yes, please provide details below

Condition:	Treating Doctor's Name:	Phone Number:

Did any one witness the accident?:

○ Yes ○ No

If yes, please provide details below

Witness 1 Name:	Witness 1 Contact Details:
Witness 2 Name:	Witness 2 Contact Details:

(2) Illness Claim Details

Date and Time You first became aware of the illness or condition:

Please provide full details of the illness or condition You are suffering from:

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 provide details of all the doctors that You have consulted for this illness or condition

Doctors Name:

Address:

(2) Illness Claim Details *(continued)*

Phone Number:

Treatment provided/dates:

Doctors Name:

Address:

Phone Number:

Treatment provided/dates:

Doctors Name:

Address:

Phone Number:

Treatment provided and dates

If You were admitted to a hospital, or treated as an outpatient, please give details

Name of Hospital: Date/Time admitted:

Date/Time discharged: Inpatient or outpatient:

Have You ever had this or a illness or condition in the past?

○ Yes ○ No

If yes, please provide details below

Condition: Treating Doctor's Name:

Phone Number: Date First Treated:

(2) Illness Claim Details *(continued)*

Condition:

Treating Doctor's Name:

Phone Number:

Date First Treated:

Condition:

Treating Doctor's Name:

Phone Number:

Date First Treated:

(3) General Information

Please provide details below of Your normal family doctor(s):

Doctor's Name:

Phone Number:

Address:

Doctor's Name:

Phone Number:

Address:

Have You ever lodged a personal accident/illness claim before?:

○ Yes ○ No

If so, please provide full details of claim:

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:

EFT Details

Please provide your preferred bank account details below. Settlement will be made into this account, if required:

Account Name:

Name of Bank:

Branch:

BSB Number:

Account Number:

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 authorisation 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.

Attending Physicians Statement

1. Please refer to a copy of the statement form at the end of this document, which is to be completed by the doctor attending You.
2. Once completed, include the form in an envelope and post to the below address.

Declaration

I/We solemnly and sincerely declare:

That the information supplied on this Claim Form and Statement of Claim is true in every respect.

1. I/We understand that the claim may be refused if information is withheld, false, misleading or concealed
2. That there was no other insurance covering this loss current at the date of this incident.
3. I/We acknowledge that this Claim Form is a Legal Document and as such may be used in any legal proceedings resulting from this claim.

Submission

○ By ticking this box, I acknowledge this declaration and acknowledge that the information I have supplied to be true and accurate to the best of my knowledge.

Please print name:

Signed:

Date:

/ /

Please complete and return this form to:

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Facsimile: 08 8333 0034

Attending Physicians Statement *(to be completed by the doctor attending You)*

Important Note

Any charge for this statement must be borne by the patient.

Patient Details

Patients Surname: Patients Given Name(s):

Patients Address:

Patients Date of Birth: Height:

Weight: Gender:

Occupation: Are you the patients regular treating doctor?

○ Yes ○ No

Illness/Condition (disregard if patient has an injury and proceed to next section)

Please give a complete diagnosis of this illness/condition:

Please confirm what you believe is the cause of your patients illness/condition:

When did the patient first consult you regarding this illness/condition?:

Date / Time:

To your knowledge, was this the first time the insured obtained medical treatment or advice for their illness/condition?:

○ Yes ○ No

If no, please provide details of initial consultation/treatment:

When was the illness first contracted?:

Date / Time:

When did the symptoms become evident?:

Date / Time:

Has the patient suffered a similar illness/condition?:

○ Yes ○ No

If yes, please provide details:

Injury

Please give a complete diagnosis of the injury:

Please confirm what you believe is the cause of your patients injury:

When did the patient suffer the injury?:

Date / Time:

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

When did the patient first consult you regarding this illness/condition?:

Date /Time:

To your knowledge, was this the first time the insured obtained medical treatment or advice for their illness/condition?:

○ Yes ○ No

If no, please provide details of initial consultation/treatment:

Has the patient told you if they were under the influence of drugs or alcohol when the injury occurred?:

○ Yes ○ No

If yes, please provide details, including confirmation if a drug/alcohol test was taken and the results:

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?:

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?:

Date:

- All of the tasks of his/her occupation?:

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?:

No. of 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:

Date:

What is the current prognosis?:

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

Doctors Name:

Qualification:

Address:

Telephone No.:

Email:

Signed:

Date:

/ /