NRMA BUSINESS INSURANCE

Personal Accident & Illness Claim Form

Claim No. ______

Policy No. ______

Expiry Date ___ / ___ / ___

Excess ______

THE COMPLETION OF THIS FORM AND ITS RECEIPT BY US IS NOT AN INDICATION THAT WE ACCEPT ANY LIABILITY.

PLEASE PRINT IN BLOCK LETTERS and answer all Questions ☑ where applicable (Provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

THE FORM SHOULD BE COMPLETED AND RETURNED TO NRMA BUSINESS INSURANCE WITHIN 7 DAYS OF RECEIPT BY THE INSURED.

ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.

INSURED'S DETAILS

Name of Insured ______

Address ______

______ Postcode ______

Telephone No. ______ (Private) ______ (Mobile) ______ (Business)

Contact Name ______ Telephone No. ______ Facsimile No. ______

(1) Are you registered for GST? No ☐ Yes ☐

(2) What is your Australian Business Number (ABN)? ☐☐☐☐☐☐☐☐☐☐☐☐☐☐

(3) What was your 'Entitlement to an Input Tax Credit' (EITC%) on your premium payment for this policy? ______ %

GENERAL QUESTIONS - To be completed by the Insured

(1) What date was the Insured Person first unable to attend to their usual duties? ___ / ___ / ___

(2) How long has the Insured Person been disabled from engaging in or attending to their usual business as the result of the accident/illness?

Totally From ___ / ___ / ___ To ___ / ___ / ___ **Partially** From ___ / ___ / ___ To ___ / ___ / ___

(3) Has the Insured Person previously suffered from a similar illness or injury? No ☐ Yes ☐

If "yes", please give details including the medical practitioners who provided advice and/or treatment. ______

______

______

INSURED PERSON'S DETAILS - To be completed by the Claimant

(1) Name Mr / Mrs / Miss / Ms ______

Address ______

______ Postcode ______

Age ______ Occupation ______ Telephone No. ______ Sex Male ☐ Female ☐

(2) Have you ever been affected by any illness, disease, physical defect or infirmity? No ☐ Yes ☐

If "yes", please give details. ______

______

______

(3) Have you required medical or surgical treatment during the past five years? No ☐ Yes ☐

If "yes", please give details. ______

______

______

(4) Are you entitled to claim from any other insurance policies in respect to this disability? No ☐ Yes ☐

If "yes", please give details. ______

ACCIDENTAL INJURY ONLY CLAIM DETAILS

(1) When did the accident happen? Date ____/______/______ Time ________ am/pm

Where did the accident happen? ______________________________

(2) Describe fully how the accident occurred. ______________________________

(3) Were there any witnesses to the accident? No ☐ Yes ☐

If "yes", please give details. Name ______________________________

Address ______________________________

(4) Are you employed? No ☐ Yes ☐

(5) Did the injury occur at work? No ☐ Yes ☐

(6) Describe nature of injuries sustained by the Insured Person. ______________________________

(7) On what date did the Insured Person first seek medical advice/treatment for the accident? Date ____/______/______

(8) Please give details of all your treating medical practitioners in realtion to the illness. ______________________________

ILLNESS ONLY CLAIM DETAILS

(1) What date did the Insured Person become aware of the illness? ____/______/______

(2) On what date did the Insured Person **first** seek medical advice/treatment for the illness? ____/______/______

(3) What date was the Insured Person diagnosed as suffering from the illness? ____/______/______

(4) Are you employed? No ☐ Yes ☐

(5) Did the illness occur through work? No ☐ Yes ☐

(6) Describe the nature of the illness. ______________________________

(7) Please give details of all your treating medical practitioners in realtion to the illness. ______________________________

DECLARATION AND AUTHORISATION

I/We hereby declare that the foregoing statements are true and correct. I/We consent to the Insurer, in assessing or otherwise dealing with this claim, disclosing my/our personal information to or collecting my/our personal information from related entities, other insurers, insurance reference bureaux, investigators, or other parties providing services to the Insurer.

I/We authorise any Doctor, Hospital, Clinic or other person to give to the Insurer any and all information concerning my current and/or past medical history. A photographic copy of this authorisation shall be as valid as the original.

Name ______________________ Name ______________________

Signature ______________________ Signature ______________________

Date ____/______/______ Date ____/______/______

NOTE: FAILURE TO HAVE THE ATTACHED CERTIFICATE OF MEDICAL PRACTITIONER COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER WILL DELAY THE PROCESSING OF YOUR CLAIM. ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.

DEFINITIONS

Total Disablement
Injury or Illness which results in the claimant being entirely disabled from attending to his/her normal duties, profession, business or occupation.

Partial Disablement
Injury or Illness which results in the claimant being restricted to only attending to part of their normal duties, profession, business or occupation.

NRMA
BUSINESS INSURANCE

Certificate of Medical Practitioner

Claim No. ______

Policy No. ______

Expiry Date ___ / ___ / ___

Excess ______

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PLEASE PRINT IN BLOCK LETTERS and answer all Questions ☑ where applicable (Provide full and complete answers). If a particular question does not apply, please write "Nil" in the space provided. If the space provided below is insufficient to advise all the details, please attach a separate sheet.

PLEASE ENSURE THIS FORM IS COMPLETED BY A DULY QUALIFIED AND REGISTERED MEDICAL PRACTITIONER.

ANY FEE INCURRED IS PAYABLE BY THE CLAIMANT.

MEDICAL PRACTITIONER'S DETAILS

Name Mr Mrs Miss Ms Other ______

Address ______ Postcode ______

Qualifications ______

Telephone No. ______ Mobile No. ______ Facsimile No. ______

CLAIMANT'S DETAILS

Name Mr Mrs Miss Ms ______

Address ______ Postcode ______

(1) State fully the nature of the injuries or diagnosis of illness. *(If an eye or limb is involved, state whether left or right)*

______

(2) What are the current symptoms? ______

(3) So far as you are aware, how did the injury arise? ______

(4) Are the injuries sighted consistent with what was conveyed to you as the cause? No ☐ Yes ☐

If "no", please give details. ______

(5) Is the claimant suffering from any pre-existing condition which might in any way contribute, aggravate or otherwise impair the person's ability to return to their business, profession or occupation? No ☐ Yes ☐

If "yes", please provide details. ______

(6) When did the claimant first consult you in connection with the accident or illness? ___ / ___ / ___

(7) Has the claimant previously been treated by you for a similar illness or injury? No ☐ Yes ☐

If "yes", please provide details. ______

(8) Are you the claimant's usual Medical Practitioner? No ☐ Yes ☐

If "yes", how long have you known the Claimant? Years ______ Months ______

(9) Is the Claimant still under your care? No ☐ Yes ☐

If "yes", please provide details of the period of disablement (Refer to the Definitions).

Total From ___ / ___ / ___ To ___ / ___ / ___ **Partial** From ___ / ___ / ___ To ___ / ___ / ___

(10) If disablement, in whole or part, continues - how long is the incapacity likely to continue?

Total From ___ / ___ / ___ To ___ / ___ / ___ **Partial** From ___ / ___ / ___ To ___ / ___ / ___

(11) Any other remarks or comments. ______

MEDICAL PRACTITIONER'S SIGNATURE

Name ______ Signature ______ Date ___ / ___ / ___

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