Claims X Journey

Claim form

ReddiFund Mutual Benefit Fund Discretionary Trust.
If you need assistance with filling out this form, contact us on 1300 375 723 or claims.aus@claimsx.com.au

Important information

We will act on your claim upon receipt of this form. Issue of this form is not an admission of liability.

You can assist in the assessment of your claim if you:

1. Fully complete this form and supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents may result in a delay in assessing your claim.
2. Provide a comprehensive description of the circumstances of the loss, completing all relevant sections.
3. Provide additional supplementary information on a separate page if there is not enough space on this claim form.
4. Forward the completed claim form to Claims X at claims.aus@claimsx.com.au.

Member details

Member name:

Phone number:

Email:

Postal address:

State: Postcode:

Occupation:

Date of birth:

Describe your usual duties:

Employer's name:

Address:

Phone: State: Postcode

Banking details

Account name:

BSB:

Account number:

Particulars of your journey

Accident date:	Time:
Where did the accident occur?	
What address did the journey commence from?	
Is this your usual place of residence or last place of business activity for the day? If **yes**, provide details	☐ Yes ☐ No
What time did the journey commence?	
What time did you commence work?	
What time did you finish work?	

Describe the route and method of transport between home and work or vice versa naming streets in order:

Did you divert from your usual route? If **yes**, please explain why? ☐ Yes ☐ No

Please give a full description below of injury for which you are claiming:

How were you injured?

What injuries did you receive?

Where were you going when you were injured?

Details of person who witnessed the accident

Witness name:	
Address:	
State:	Postcode:
Phone:	

If the injury resulted from a motor vehicle accident were you required to undergo a breath analysis or blood test? If **yes**, please supply a copy of the result	☐ Yes	☐ No
When did you first consult a Doctor for this condition?	Date:	Time:
When did you become totally disabled (unable to work)?	Date:	Time:
If still disabled, when do you expect to return to work?	Date:	Time:
If you have returned to work, when were you able to again perform:		
a) One or more of the material tasks of your operation?	Date:	
b) All of the tasks of your occupation?	Date:	

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

Name of hospital:

Address:

From/To:

In/Outpatient:

Details of all attending physicians:

Doctors name:

Address:

Phone:

Have you ever had this or a similar condition in the past? If **yes**, please give details	☐ Yes	☐ No

Condition:

Treated by:

Date:

Other insurance

Do you have any other Policy of Insurance which provides a capital or lump sum benefit in the event of an injury? If **yes**, please give name of Insurance company	☐ Yes	☐ No
Do you have any other Policy of Insurance which provides weekly benefits in the event of an injury? If **yes**, please give name of Insurance company	☐ Yes	☐ No
Name of Insurance company	☐ Yes	☐ No
Are you making or entitled to make any other Insurance or compensation claim in respect of this disability?	☐ Yes	☐ No
Workers' Compensation	☐ Yes	☐ No
Motor Accident Commission	☐ Yes	☐ No
Have you ever lodged a Personal Accident claim before? If **yes** to any of the above please provide details:	☐ Yes	☐ No

Declaration and medical authority

1. I, _____, declare that the information provided by me in relation to this claim is true and complete.
2. I authorise any doctor, dentist, physiotherapist, company, other legal entity, person, service provider to disclose to Claims X Pty Ltd all information associated with my current claim.
3. I understand that the claim may be declined if the information supplied is untrue and I have not provided all relevant facts.
4. I agree to supply any further information that may be requested of me in connection with my claim.
5. I have read and accept the Privacy Collection Statement provided with this form and Claims X Pty Ltd's Privacy Policy.
6. Where I have provided information about other individuals, I have made those persons aware of the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy provided with this form and I have obtained their consent to the information being provided in accordance with the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy.

Signature of Claimant:

Date:

Income details (skip if not applicable)

If self-employed

If the claimant is not an employee (i.e. a self-employed contractor) then the gross weekly income derived from personal exertion in their usual occupation, after deducting any expenses necessarily incurred in deriving that income, averaged over the number of weeks so engaged during the twelve (12) months immediately preceding the date of disablement giving rise to claim, **must be supplied.**

Your accountant's name:

Address:

Telephone no:

Please confirm employment/position status
(i.e. Director / Partner / Sole Trader / Other):

If employed as a wage earner, to be completed by your employer

I hereby certify that _____ has been unable to attend their usual occupation with the company as a result of an injury/injuries/sickness suffered on _____.

What was the employee's last day at work?

When is the employee expected to / did resume duties?

When did the claimant commence employment with this company?

Please describe the claimant's usual occupation listing details of primary responsibilities:

Has the employee lodged or intend lodging a Workers' Compensation claim? If **yes**, please provide a copy of confirmation of acceptance or rejection (letter) from the Insurer. ☐ Yes ☐ No

Is there any additional information you would like to provide in relation to the submission of this claim?

Please see the attached **Declaration of pre-disability earnings** section of the claim form to be completed by you or your paymaster.

Name of company:

Postal address:

Signature of supervisor or paymaster: Dated:

Name of supervisor or paymaster (please print) Dated:

Email:

Phone:

Declaration of pre-disability earnings

Employee's name

Please provide a breakdown of the total earnings during the fifty-two (52) weeks prior to disablement, or for the period of employment if less than fifty-two weeks.

Prior to completing the following information, please read the definition of each of the Earnings Categories

All earnings listed should be before any deductions (i.e. income tax, etc), and should exclude superannuation.

Earnings Category	Definition	Total Earnings
Total Ordinary Earnings	*Ordinary Earnings are the gross wages of the employee excluding allowances, loadings, bonuses, and overtime. This amount should include all paid leave, such as sick leave, personal leave, annual leave, and rostered days off.*	$
Total Allowances	*Allowances can include, but are not limited to tool allowances, industry allowances, trade allowances, shift loadings, special rates, qualification based allowances (such as first aid, laser safety officer allowances, etc).*	$
Total Overtime	*Overtime refers to any and all overtime earnings regardless of the rate.*	$
Other Earnings	*If applicable, please specify the nature of Other Earnings included:*	$
Total Earnings	*Total of the above*	$
Total weeks wages included in above calculations		weeks

Employer Declaration

To avoid delays, please ensure that this form is fully completed with ALL "Ordinary Time Earnings" as detailed in definition above. Please note that Weekly Benefit entitlements will be calculated upon the information/declaration that you provide.

1. I declare that to the best of my knowledge the information provided above is true, accurate and complete.
2. I understand that the claim may be declined if the information supplied is untrue and I have not provided all relevant facts.
3. I have read and accept the Privacy Collection Statement provided with this form and Claims X Pty Ltd's Privacy Policy.
4. Where I have provided information about other individuals, I have made those persons aware of the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy provided with this form and I have obtained their consent to the information being provided in accordance with the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy.

Payroll officer's name:

Date:

Signature:

Doctor's statement

Important: please print legibly – this form cannot be accepted otherwise

1. The patient is responsible for any fee for this statement.
2. This form can only be completed by the treating Medical Practitioner or Surgeon (not Physiotherapist).
3. Dashes or blank spaces are not acceptable.
4. If the regular or usual doctor was not the treating doctor, this statement will also have to be completed by the claimant's regular doctor. If the claimant has been referred to another physician for treatment, a subsequent statement may be required to be completed by that physician.

1. Patient's full name:

2. How many years or months has the claimant been your patient/under your care?

a) What date were you first consulted by the claimant in connection with the present Sickness or Accident? Date:

b) How long had the patient been experiencing symptoms prior to consulting you for the first time?

c) Are these symptoms consistent with the current diagnosis?

d) When do you believe this condition manifested?

3. What is the exact nature of the present sickness or injury?

a) If X-Ray examination or other tests have been made, state finding and/or quote report.

4. What is the (proximate) cause of the disabling condition?

a) If X-Ray examination or other tests have been made, state finding and/or quote report. ☐ Yes ☐ No

b) Would you support a Workers' Compensation claim? If **no**, please explain why not ☐ Yes ☐ No

5. Has the patient previously suffered from the same or similar condition? ☐ Yes ☐ No

a) Dates of consultation:

b) Diagnosis

c) Was this occurrence/recurrence expected? If **yes**, why? ☐ Yes ☐ No

d) Do you expect any further recurrence of this condition? If **yes**, please provide details: ☐ Yes ☐ No

6. Is there anything in the patient's medical history that may have contributed or aggravated, either directly or indirectly to the Injury/Sickness? If **yes**, please provide details ☐ Yes ☐ No

7. Is there anything in the patient's medical history that may be likely to delay the recovery? If **yes**, please provide details and advise how long recovery may be delayed ☐ Yes ☐ No

8. Please provide summary details of all past and present medical advice and treatment provided to the patient in respect of his/her current disablement.

9. Do you consider treatment other than that being received is essential to recovery? If **yes**, please provide details. How might this promote a return to work? ☐ Yes ☐ No

10. Have you referred the patient to other specialist services or treatment? If **yes**, please provide details and a telephone contact number: ☐ Yes ☐ No

11. If the claimant has already been hospitalised, please provide details below:

Name of hospital:

Dates:

12. Is treatment likely to be prolonged by any complications? If **yes**, please provide details and advise how long treatment may be prolonged: ☐ Yes ☐ No

13. Has the claimant continued to follow medical advice? If **no**, please provide details: ☐ Yes ☐ No

14. Is there any reason or evidence to suggest the patient was under the influence of intoxicants at the time of the accident or that intoxicants may have caused the injury? ☐ Yes ☐ No

15. When was the claimant obliged to cease work?

16. Return To Work:

When did or when do you realistically expect the claimant to resume work?	Date
Full unrestricted duties	Date
Modified duties, if necessary	Date
Normal duties in reduced capacity (i.e . restricted hours)	Date
If unable to return to work in a partial capacity, please provide an explanation.	Date

17. I hereby certify that the patient has been and or will be totally disabled from carrying out his / her usual occupational duties as follows:

From: To (inclusive):

18. Additional remarks (e.g. prognosis, life expectancy, occupational rehabilitation, surgery waiting list):

Doctor's declaration

- I hereby certify that I have personally examined the abovenamed claimant and that in my opinion the statements made by me in this claim form are true and correct.
- I have read and accept the Privacy Collection Statement provided with this form and Claims X Pty Ltd's Privacy Policy.
- Where I have provided information about other individuals, I have made those persons aware of the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy provided with this form and I have obtained their consent to the information being provided in accordance with the Privacy Collection Statement and Claims X Pty Ltd's Privacy Policy.

Name:

Provider Number:

Qualifications:

Telephone:

Address:

Email Address:

Date:

Signature:

Collection Statement under the Privacy Act 1988 (Cth)

In accordance with the Privacy Act 1988 (and subsequent amendments), Claims X Pty Ltd ABN 57 649 962 701, AFSL 530894 (we, our, us, Claims X), draws your attention to the following:

- We may collect personal information or sensitive information about you.
- We are collecting the information principally for the purpose of claims handling and settling services.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, other parties which may assist us in assessing your claim, agents and Claims X related group companies, such as Howden Insurance Brokers (Australia) Pty Ltd ABN 79 644 885 389, AFSL 539613 (Howden) and Alternative Risk Management Services Pty Ltd ABN 70 649 963 191 (ARMS). Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- Our related group companies may provide you with information about other products and services including but not limited to an alternate risk management solution offered through ARMS. ARMS and Howden will use and disclose your information to assist in the administration, promotion and risk management of the applicable discretionary trust.
- Please read our Privacy Policy on https://www.howdengroup.com/au-en/privacy-policy for further information in relation to how we and our related group companies collect, store and use your information. You may also request a copy from our privacy officer whose details are below.
- If you would like further information contact our privacy officer on the contact details below:

  Post: Claims X Pty Ltd
  Level 23, 20 Bond Street
  Sydney, NSW 2000

  Email: privacy.pacific@howdengroup.com

- By providing this information, you agree to us collecting, using and disclosing your personal or sensitive information as outlined in this Collection Statement and our Privacy Policy.
- If you do not provide all or part of the information requested, we may be unable to process your application, administer your claim or provide other required services, or your application for insurance or membership of a discretionary trust arrangement may be declined or you may prejudice your insurance cover or cover under a discretionary trust.
- You have the right to request access to, and correct, any personal information that we hold about you, subject to the provisions of the Privacy Act 1988 (Cth).
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- If you provide us with personal information about other individuals, you must ensure that those persons have been made aware of the above matters. Where the information collected relates to health, criminal record or other sensitive information as defined in the Privacy Act 1988, you must obtain it with the individual's prior consent.