Claims X
Journey claim form

ReddiFund
More than Redundancy

ReddiFund Mutual Benefit Fund Discretionary Trust

If you need assistance with filling out this form, contact 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. Supply all appropriate information/documentation and sign and date the declaration. Failure to fully complete the claim form and provide all supporting documents as indicated may result in a delay in processing your claim.
2. Provide a comprehensive description of the circumstances of the accident/injury or sickness.
3. Provide additional supplementary information on a separate pages if there is not enough space on this claim form.
4. Forward the completed claim form to Claims **X** using the above email address.

Part 1

Member details

Full name			
Phone		Email	
Residential address State/Postcode			
Occupation	Date of birth	Height	Weight
Describe your usual duties			
Employer's name			
Address			
Phone	State	Postcode	

Banking details

Account name	
Account number	
BSB	

Part 2

GST

Registered for GST? Y ☐ N ☐

If **yes**, please enter the Australian Business Number (ABN) and Input Tax Credit (ITC) entitlement percentage below

ABN ITC % (from when your current cover began)

If you don't advise or you, understate the availability of an Input Tax Credit, you may have a liability to pay tax on the claim payment.

IMPORTANT – If more than one named insured is claiming for the loss, please supply details of ABN and ITC percentages applicable to each entity on a separate page and attach to claim form.

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 Y ☐ N ☐

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? Y ☐ N ☐

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			Y ☐	N ☐
When did you first consult a Doctor for this condition?	Date	Time	AM ☐	PM ☐
When did you become totally disabled (unable to work)?	Date	Time	AM ☐	PM ☐
If still disabled, when do you expect to return to work?	Date	Time	AM ☐	PM ☐

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/Out patient

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	Y ☐	N ☐
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	Y ☐	N ☐
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	Y ☐	N ☐
Name of Insurance company		
Are you making or entitled to make any other Insurance or compensation claim in respect of this disability?	Y ☐	N ☐
Workers' Compensation	Y ☐	N ☐
Motor Accident Commission	Y ☐	N ☐
Have you ever lodged a Personal Accident claim before? If **yes** to **any** of the above please provide details:	Y ☐	N ☐

Part 3

Declaration of earnings

IMPORTANT INFORMATION

1. You should refer to your policy wording for the definition of "earnings" to enable you Accountant or Employer to complete this section in accordance with the policy.
2. You may be required to supply proof of your income by submitting copies of your personal and/or business income tax returns for the full financial year immediately preceding the injury for which you are now claiming.

Section 1 – Self-employed person (to be completed by your Accountant)

Business/Trading name	
Business address	
State	Postcode
Phone	
Was the business fully operational and was the Insured fully employed at the time of suffering the accident? If **no**, please provide details	Y ☐ N ☐
Does the business have Workers' Compensation Insurance?	Y ☐ N ☐
Please state the current weekly earnings	$
Accountant's name	
Accountant's signature	

Section 2 – Employed persons (to be completed by Employer)

Employer's name		
Employer's address		
State	Postcode	Phone
Please state the current weekly earnings		$
Is the insured person entitled to Workers' Compensation benefits? If **yes**, please provide details of payments		Y ☐ N ☐
(a) Weekly rate		$
(b) Monies paid to date		$

Was the insured person in your employ at the time of suffering the injury or illness?	Y ☐ N ☐
Please advise the insured person's salary at the date of the injury	$
Officer's name	
Officer's position	
Signature	
Phone Dated	

Authority and declaration

☐ I wish to report this incident, but do not want to claim against the Trust at this time;

☐ I submit this information in support of a formal claim against the Trust

1. I hereby authorise any hospital, physician or other person who has attended me to furnish Claims X Pty Ltd, or its representatives, any and all information with respect to any sickness or injury, medical history, consultation, prescriptions or treatment, copies of all hospital or medical records. I agree that a Photostat copy or facsimile copy of this authorisation shall be considered as effective and valid as the original.
2. I/we do hereby declare that the foregoing answers are true and correct, that I/we have in no manner caused the said accident by any fraud or willful misrepresentation sought unjustly to benefit by the said accident and that the information detailed above is a true and faithful account of the actual incident.
3. I/we hereby undertake and agree to notify the Trust's Claims Manager immediately if any of the lost or stolen property mentioned in this claim is subsequently recovered, and at the option of the Trust's Claims Manager, to return the property or to refund the amount of money received, by way of compensation in respect thereof.
4. No information likely to affect the acceptance of this claim has been withheld.
5. I/we understand that this claim may be refused if any information is false, or inaccurate or concealed.
6. I/we the undersigned hereby acknowledge and agree to the information contained herein (including our personal information), being shared with the other members of our Discretionary Trust ("Trust") as part of the Trust's Risk Management processes and Reporting criteria with Reddifund, as it may be required to assist in the management of this claim and the administration of the Trust.

Part 4

Attending physicians statement (to be completed by your attending physician)

The Insured is responsible for completion of this form without expense to the company

Patient's name

Patient's address

When did the patient suffer the injury?

What were the circumstances surrounding the injury?

When did the patient first receive medical treatment?

Please give a complete diagnosis of this condition.

Please give results of any objective findings (detail tests done and findings)

Test	**Findings**
X-rays	
Other tests	

Was the patient confined to hospital? If **yes**, please advise the and address of hospital Y ☐ N ☐

Name of hospital

Address of hospital

Period of confinement From To

What other treatment has the patient undergone?

What other treatment is required?

History

Was there a previous history or a similar condition? If **yes**, please state condition and advise when previous treatment was given Y ☐ N ☐

How long have you known the patient?

Are you the regular General Practitioner? If **not**, please advise who is? Y ☐ N ☐

Degree of disability	
When was the patient obligated to cease work?	
If patient is still unfit for work, when approximately will the patient be able to resume?	
If patient has recovered, when was the patient able to resume work?	
If patient is still unfit for work, will they be able to resume in the near future? If **yes**, please advise the nature of underlying conditions and how they affect disability and recovery	Y ☐ N ☐
Please advise names and addresses of other treating physicians:	
If you have terminated treatment, please advise the date:	
What is the current prognosis?	
Are there any further remarks which may assist in assessing this condition?	
Is there permanent disability at present? If **yes**, please explain, giving estimated percentage of loss of function	Y ☐ N ☐

Physicians declaration

Name (please print)	
Signed	
Dated	
Address	
State	Postcode
Phone	

Collection Statement under Privacy Act 1988

In accordance with the Privacy Act 1988 (and subsequent amendments), we Alternative Risk Management Services (ARMS) and Claims X, as related companies of the Howden group, draw 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 approaching the (re)insurance market, placing insurance, assessing and advising you on your insurance needs, claims handling or risk management (depending on your requirements). Other purposes include providing you with information about other Claims X products or services. If you are applying for or renewing insurance or membership, or membership of an Alternative Risk Management Services Discretionary Trust Arrangement (DT Arrangement), the information is required pursuant to your Duty of Disclosure under the Insurance Contracts Act 1984, the Marine Insurance Act 1909 or at common law.
- The information we collect may be disclosed to third parties including but not limited to (re)insurers, insurance intermediaries, service providers, finance providers, advisers, agents and Claims X related Group companies, such as Howden Insurance Brokers (Australia) Pty Ltd. Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore. Please read our Privacy Policy on Howden's website if you would like further information or contact our Privacy Officer on the contact details below.
- By providing this information, you agree to us collecting, using and disclosing your personal or sensitive information as outlined in this Collection Statement.
- 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 DT Arrangement may be declined or you may prejudice your insurance cover or cover under a DT Arrangement.
- 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.
- 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.
- Our Privacy Policy can be made available on request or can be accessed on Howden's website https://www.howdengroup.com/au-en/privacy-policy

For further information or to make a complaint regarding Claims X's Privacy Policy, contact your Broker, Claims Manager or the Privacy Officer for Howden and Claims X.