JOURNEY CLAIM FORM

THIS FORM SHOULD BE COMPLETED AND RETURNED TO:
Echelon Claims Services - GPO Box 1693, Adelaide SA 5001 Email: ecssa@echelonaustralia.com.au Phone: 08 8235 6455 or Free call 1800 640 009

YOUR DETAILS			
Full Name:			
Residential Address:			
State:		Postcode:	
Telephone Number:			
Email:			
Occupation:			
Describe your usual duties:			
Date of Birth:			
Height:		Weight:	
Employer's Name			
Address			
State:		Postcode:	
Telephone Number:			

GST		
Are you registered for GST?	YES ☐	NO ☐
If YES, please enter the Australian Business Number (ABN) and Input Tax Credit (ITC) entitlement percentage below -		

ABN No.		ITC % (at start of current period of cover)	

If you fail to advise the availability of an Input Tax Credit or understate its availability, then 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					
Date of Accident:		Time:		AM ☐	PM ☐
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?				YES ☐	NO ☐
If YES, please give details:					
What address were you travelling to?					
Is this your usual place of residence or first place of business activity for the day?				YES ☐	NO ☐
If YES, please give details:					
What time did the journey commence?				AM ☐	PM ☐
What time did you commence work?				AM ☐	PM ☐
What time did you finish work?				AM ☐	PM ☐
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?				AM ☐	PM ☐
If YES, please explain why?					
Please give a full description below of injury for which you are claiming:					
How were you injured?					

What injuries did you receive?						
What were you doing when you were injured?						
Details of person who witnessed the accident:						
Person:						
Address:						
State:		Postcode:				
Telephone Number		Mobile Number:				
If the injury resulted from a motor vehicle accident were you required to undergo a breath analysis or blood test?			YES ☐	NO ☐		
If YES, please supply a copy of the result:						
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 occupation?			Date:			
b) All 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	Telephone No.	
Have you ever had this or a similar condition in the past?		YES ☐	NO ☐
If YES, please give details:			
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?		YES ☐	NO ☐
If YES, please give name of insurance company			
Do you have any other Policy of insurance which provides weekly benefits in the event of an injury?		YES ☐	NO ☐
If YES, please give name of insurance company:			
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 ☐
Name of Insurance Company:			
Have you ever lodged a Personal Accident claim before?		YES ☐	NO ☐
If YES to ANY of the above please provide details:			

DECLARATION OF EARNINGS

IMPORTANT INFORMATION

1. You should refer to your policy wording for the definition of “earnings” to enable your 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 PERSONS (To be completed by your Accountant)

Business/Trading Name:			
Business Address:			
State:		Postcode:	
Telephone Number:			
Was the business fully operational and was the Insured fully employed at the time of suffering the accident?		YES ☐	NO ☐
If NO, please provide details -			
Does the business have Workers’ Compensation insurance?		YES ☐	NO ☐
Please state the Current Weekly Earnings?		$	
Accountants Name:			
Accountant’s Signature:			

SECTION 2 EMPLOYED PERSONS (to be completed by Employer)

Employer’s Name:			
Employer’s Address:			
State:		Postcode:	
Telephone Number:			
Please state the Current Weekly Earnings?		$	
Is the insured person entitled to Workers Compensation benefits?		YES ☐	NO ☐
If YES, please provide details of payments -			
(a) Weekly Rate		$	
(b) Monies paid to date		$	
Was the insured person in your employ at the time of suffering the injury or illness?		YES ☐	NO ☐
Please advise the insured person’s salary at the date of injury -		$	

Officer's Name:			
Officer's Position:			
Signature:			
Telephone Number:		Dated:	

AUTHORITY & 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;

I hereby authorise any hospital, physician or other person who has attended me to furnish Echelon Claims Services, 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.

I/we do hereby declare that the foregoing answers are true and correct, that I/we have in no manner caused the said incident by any fraud or wilful misrepresentation sought unjustly to benefit by the said incident and that the information detailed above is a true and faithful account of the actual incident.

I/we hereby undertake and agree to notify the Trust's Claims Manager immediately if any of the income paid to me under this claim is recovered by me in a 3rd party claim against another driver and undertake to refund the amount of money received by way of compensation in respect thereof.

No information likely to affect the acceptance of this claim has been withheld.

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.

BANKING DETAILS

Account Name:	
BSB:	
Account Number:	
Email Address:	
Please Print Name:	
Signature:	
Dated:	

PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM.

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	
1.	X-Rays		
2.	Other Tests		
Was the patient confined to hospital?		YES ☐	NO ☐
If YES, please advise the name and 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?	YES ☐	NO ☐
If YES, please state condition and advise when previous treatment was given:		
How long have you known the patient?		
Are you the regular General Practitioner?	YES ☐	NO ☐
If NOT, please advise who is?		

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 patient able to resume work ?		
If patient is still unfit for work, when approximately will the patient be able to resume?	YES ☐	NO ☐
If YES, please advise nature of underlying conditions and how they affect disability and recovery:		
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 any permanent disability at present?	YES ☐	NO ☐
If YES, please explain, giving estimated percentage of loss of function?		

Name: (Please Print)			
Signed:			
Dated:			
Address:			
State:		Postcode:	
Telephone Number:			

ECHELON AUSTRALIA PTY LTD

ABN 96 085 720 056

COLLECTION STATEMENT UNDER PRIVACY ACT 1988 (Cth)

In accordance with the Privacy Act 1988 (Cth) and any subsequent amendments (the Privacy Act), we Echelon Australia Pty Ltd (Echelon), including Echelon Claims Services, draw your attention to the following:

- We may collect personal information about you by means of the enclosed document.
- We are collecting the information principally for any of the following purposes (depending on your requirements):
    - approaching the (re)insurance market;
    - placing insurance or providing alternative coverage;
    - assessing and advising you on your insurance or coverage needs;
    - providing claims handling or risk management services;
    - providing you with information about other JLT products or services; and
    - administering payments to you.
- 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 other Echelon related group companies, such as JLT Risk Solutions Pty Ltd and JLT Group Services Pty Ltd. Echelon is a business of Marsh and McLennan Companies (MMC). Those entities will hold and use the data in accordance with their own privacy policies which may include disclosure to third parties located offshore.
- Your personal information may be sent to our administrative processing centers in Mumbai (India) or Kuala Lumpur (Malaysia). It may also be sent to: Bermuda, Brazil, China, Dubai, Hong Kong, Ireland, Japan, Singapore, South Korea, United Kingdom and the United States for the purposes of outsourcing Insurance Broking, Intermediary and Risk Advisory Services; and Canada, India, United Kingdom and the United States for the purposes of outsourcing Business Support Services (for example, IT systems administration and payment processing).
- 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, you must obtain it with the individual's consent.
- By providing this information, you agree to us collecting, using and disclosing your personal 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 or claim or provide other required services.
- 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.
- To assist us in maintaining correct records we ask you to inform us of any changes in your personal information provided as they occur.
- We will use and disclose your personal information in accordance with our Privacy Policy. Our Privacy Policy can be accessed on our website (https://www.echelonaustralia.com.au/privacy).
- For further information contact your Account Executive, Claims Manager or our Privacy Officer at the following address:

    Echelon Australia Pty Ltd, One International Towers, 100 Barangaroo Avenue, SYDNEY, NSW, 2000. Telephone: +61 (02) 8864 7688. Email: privacy.australia@marsh.com