

Personal Accident Claim Form

The issue of this form is not an admission of liability

THANK YOU FOR NOTIFYING US OF YOUR CLAIM

PLEASE ENSURE

- ***You fully complete every question before your doctor completes his statement. Failure to do so will result in delay in handling your claim.***
- ***If any question is not applicable please state 'N/A'***
- ***You have enclosed all requested information/documentation.***
- ***You have signed this claim form.***
- ***Your attending doctor fully completes the statement.***
- ***ALL MEDICAL CERTIFICATES MUST STATE THE REASON FOR YOUR DISABLEMENT (e.g. "medical condition cannot be accepted)***

Section 1 – To be completed by Claimant

Certificate/Policy No:	
Full Name of Insured Person:	
Date of Birth:	
Full Address:	
Postcode:	
Employers Name:	
Telephone Business:	
Telephone Home:	
Mobile:	EMAIL:



✉ **GPO Box 3181,
Melbourne VIC 3000**
☎ 03 9811 4762
📠 03 9621 2399
✉ michelle@fentongreen.com.au

OTHER INSURANCE / BENEFITS	
Are you claiming insurance or compensation from any other insurance company? e.g. Workers Compensation, Traffic Accident Commission, sports body or any income replacement.	
No:	Yes: - give details below:
Name of organisation:	
Name of Insurer & Telephone Number:	
Type of cover:	
Amount Claimed:	
DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS	
I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.	
I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim 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 reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.	
Your Signature:	
Name – print	Date:

PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account. Please complete the following:

Bank: _____

Account Name(s): _____

BSB Number: _____

Account Number: _____



✉ **GPO Box 3181,
Melbourne VIC 3000**
☎ 03 9811 4762
📠 03 9621 2399
✉ michelle@fentongreen.com.au

EMPLOYER OR PRINCIPAL CONTRACTOR STATEMENT

Claimant Name							
First day not at work							
Date of employment with the Company							
Gross Weekly Base Rate of Pay averaged over the last 12 months prior to the date of disablement							
Is there a Workers' Compensation Claim lodged or to be lodged?							
If Yes, what is the Weekly Compensation							
(Please attach all WorkCover correspondence)							
What payments have been made during the period of disablement							
WorkCover	\$	From	/	/	To	/	/
Normal Pay	\$	From	/	/	To	/	/
What is the usual occupation of the claimant?							
Has the Claimant returned to work? If YES, on what date:							
Name of Company							
Contact Details		Address					
Suburb		State		Postcode			
Telephone Number		Email					
Signature							
Name							
Position							

