HALLMARK INSURANCE

INITIAL ACCIDENT AND SICKNESS CLAIM FORM

Please complete this claim form and return to:

AU
The Claims department
Hallmark Insurance
PO Box 7395
Cloisters Square 6850

NZ
The Claims department
Hallmark Insurance
PO Box 108022
Newmarket Auckland 1146

If you have any queries regarding your claim, please contact us on **AU: 1800 800 230 or NZ: 0800 220 999 or claims@hallmarkinsurance.com.au**

IMPORTANT INFORMATION

1. Providing this claim form is not an admission of liability.
2. Without the information required on this form and as detailed in the cover letter, we will be unable to process your claim.
3. This could result in a delay on making a decision on liability.
4. If you are having any difficulties completing this claim form, please contact us on the number or email noted above.
5. If any question is not relevant to your circumstances please write N/A.
6. It may be necessary during the period of your claim for an insurance Specialist to call you.
7. It is important that you notify us of any change in circumstances during your claim at the earliest opportunity, such as a return to employment.
8. If there is not enough room within the form to provide your responses please attach any documentation that will assist us in assessing your claim.

There are three parts to this form,
Insured (your) section
Employer's section and
Treating Medical Practitioners.

You may not need to complete all three sections. Please review each section carefully.

April 2024

HALLMARK INSURANCE

INITIAL ACCIDENT AND SICKNESS CLAIM FORM

Insured to complete. If any question is not applicable to your circumstances please write N/A.

Details of Insured

1. Policy Number / Loan Number or Account Number:
2. Claim Number(s):
3. Date of Birth (dd/mm/yy): / /
4. Surname:
5. First Names:
6. Residential Address:

   Suburb/Town: State: Postcode:
7. Phone: Home: Mobile:
8. Email:

Medical Details

9a. What is the main medical condition(s) that has stopped you from working?

9b. What was the date of diagnosis for your illness /injury that has prevented you from working?

10. What was the last day you worked prior to being certified unfit with this illness /injury? / /

11. If your condition was caused by an injury/accident please provide details and date of event or if you are suffering from an illness, what are your symptoms and when did you first notice symptoms?

12. When did you first consult your usual General Practitioner for this condition? / /

13. Please provide details of other Doctors (including chiropractors, physiotherapist that you have consulted for this condition.

Name	Contact details

14. Have you returned to work?

    Yes – What date did you return to work? / /

    No – When do you expect to return to work? / /

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Occupational Details

15a. What was your occupation immediately prior to ceasing work?

15b. When did you start working with this employer? ..... / /

16. Average Hours worked per week:

17. Please provide details of your occupational duties and % of time spent performing those duties:

Duties: eg computer work	% of time performing duties eg 55%

18. Were you employed at the time you suffered the illness or injury that you are claiming for?

19. Has the doctor certified you as being unfit for your normal work duties?

20. How long were you working continuously prior to the date you were certified unfit due to this injury/illness?

21. Please provide the name and address of your employer prior to ceasing work (if you are an employee)

Employers Name:

Address:

Phone:

Only complete the next section if you are self-employed. Otherwise go to Q24.

22. If you are self-employed please provide the following details

Do you trade as: Sole Trader ☐ Partnership ☐ Company ☐ or via a Trust ☐

Name of Employing Entity:

Address:

Phone:

Nature of business:

Date Trading commenced: ..... / /

ABN

Has trading ceased

Are you in receipt of any remuneration from the business? ..... ☐ Yes ☐ No ☐ N/A

23. What is your involvement in the business post your accident or sickness?

We may need to request your Income Tax Return, Notice of Assessment and other financial information.

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Other Information - all claimants must complete

24. Are you making any other insurance claims in respect of this condition? ☐ Yes ☐ No ☐ N/A

If yes, please provide details, name of insurance company, type of claim, claim number

25. a) Are you entitled to claim an Input Tax Credit on this policy? ☐ Yes ☐ No ☐ N/A
In general; you can only claim an ITC if you are claiming the premiums for this policy as a business expense

b) If yes, please provide your Input Tax Credit Entitlement ..... %

Non-medical Authority (a separate Medical Authority following on page 6)

I authorise any other insurance company, which I have made a claim under for this condition, and my most recent employer and/or their Workers Compensation insurer to provide Hallmark with information relating to my employment including but not limited to my employment history, payroll information, employment records and termination. I authorise the credit provider to provide Hallmark General Insurance Company Ltd with information about the credit account and transactions covered by my consumer credit insurance policy to manage and assess my claim to release to:

- Hallmark Insurance and/or
- Its Authorised Representative;

all information requested by Hallmark so that they can assess this claim.

I agree that a photocopy or a scanned, electronic copy of this authorisation shall be as effective and valid as the original.

Signature of Insured ✗ Date (dd/mm/yy) / /

Name of Insured

Privacy Policy Statement

We collect your personal information so that we can process your claim, identify you for inquiries you may have, and tell you about our products and services. With respect to your claim, we will need to collect sensitive information related to your health.

By providing your information, you consent to us:

1. collecting, using and disclosing your information in accordance with our Privacy Policy; and
2. disclosing your information to third parties (such as insurers, medical professionals and ex-employers) in relation to your claim.

Our Privacy Policy can be found at www.hallmarkinsurance.com.au, and describes how we deal with your personal information. Please refer to our Privacy Policy for how you can access and correct your information, and for our complaints procedure.

You may contact our Privacy Officer on customerservice@hallmark.com.au (and to opt-out of marketing). If you provide us with personal information about someone else, please ensure you have their consent to do so.

Declaration

I declare that the information contained in this statement is true, complete and correct in every detail. I understand that if I do not give full particulars or if I provide incorrect information , my rights to obtain benefits under the policy may be prejudiced.

Signature of Insured ✗ Date (dd/mm/yy) / /

Name of Insured

Checklist – Please ensure all the relevant sections are completed and attached.

IMPORTANT NOTE: You MUST complete Medical Authority 1 OR Medical Authority 1 and Medical Authority 2 on page 6.

☐ Insured Section including Authorities

☐ Employer's Section

☐ Doctor's Section – including attachments

HALLMARK INSURANCE

Consent wording (for living adults)

Notes on releasing information about your health

Your health information includes details about all your interactions with health providers, and may include details such as your symptoms, treatment, consultations, personal medical history and lifestyle. Health providers cannot release this information about you without your consent.

We Hallmark, collect and use your health information to assess your application for cover, to assess and manage your claim, or to confirm the information you gave us when you applied for cover or made a claim. This is why we need your consent.

Each time you apply for cover or make a claim, we will ask you for a fresh consent. We will respect your privacy by only asking for the information we reasonably need, and we will tell you each time we use your consent.

Please read each Authority carefully and the explanatory notes below.

Authority 1 explanatory notes – through this Authority, with the exception of a copy of the consultation notes held by your General Practitioner/ Practice, you are consenting to any health provider releasing any health information about you in the form we ask for. This may involve, for example:

- preparing a general report and/or a report about a specific condition;
- accessing and releasing your records in SafeScript;
- releasing your hospital patient notes;
- releasing the results of any investigations they have done; and/or
- releasing correspondence with other health providers.

Authority 2 explanatory notes – through this Authority, you are consenting to any General Practitioner/Practice you have attended releasing a copy of your full record, including consultation notes, but only if we have asked them to provide a general report and/or a report about a specific condition under Authority 1, and either:

- they will be unable to, or did not, provide the report within 4 weeks; or
- the report provided is incomplete, or contains inconsistencies or inaccuracies.

Your General Practitioner maintains consultation notes to support quality care, your wellbeing and to meet legal and professional requirements. General Practitioners/Practices should only release a copy of your full record, including consultation notes, for life insurance purposes in the rare circumstances set out above.

If you choose to withhold your consent to this authority, we may not be able to process your application for cover or a claim.

Hallmark Life Insurance Company Ltd ABN 87 008 446 884 AFSL 243469 and / or
Hallmark General Insurance Company Ltd ABN 82 008 477 647 AFSL 243478 (collectively "Hallmark Insurance")
Hallmark Insurance is part of the St Andrew's Insurance Group (incorporated in Australia and operating in Australia and New Zealand)

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Authority 1 – to release any of my health information except the consultation notes held by my General Practitioner/Practice

With the exception of consultation notes held by any General Practitioner/Practice I have attended, I authorise any health provider, practitioner, practice, psychologist, dentist, allied health services provider or any hospital to access and release, in writing or verbally, any details of my health information to Hallmark, or to third parties they engage.

I agree to all the following:

- My health information can be released in the form Hallmark asks for, such as a general report, a report about a specific condition, my records in SafeScript, any hospital notes, or correspondence between health providers.
- Hallmark can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Hallmark is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature ✗ Date (dd/mm/yy) / /

Authority 2 – to release a copy of the full record, including consultation notes, held by my General Practitioner/Practice in specified circumstances

I authorise any General Practitioner/Practice I have attended to release a copy of my full record, including consultation notes, to Hallmark, or to third parties they engage, only if Hallmark has asked them for a report on my health and either:

- the General Practitioner/Practice will be unable to, or did not, provide the report within four weeks; or
- the report is incomplete, or contains inconsistencies or inaccuracies.

I agree to all the following:

- Hallmark can collect, use, store and disclose my personal information (including sensitive information) in accordance with privacy laws and Australian Privacy Principles.
- This Authority is valid only while Hallmark is assessing my claim or application for cover, or is verifying disclosures I made in connection with the cover.
- A copy or transcript of this Authority will be valid and effective, and this Authority should be accepted as valid and effective where I have signed electronically or consented verbally.

Name

Signature ✗ Date (dd/mm/yy) / /

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AU
The Claims Department
Hallmark Insurance
PO Box 7395
Cloisters Square 6850

NZ
The Claims Department
Hallmark Insurance
PO Box 108022
Newmarket Auckland 1146

Authorised Third Party (ATP) Confirmation - Claim

By completing this form, you authorise Hallmark General Insurance Company Ltd and Hallmark Life Insurance Company Ltd (collectively known as Hallmark Insurance) to disclose and discuss information relating to claims on your policy to the person nominated below. We will only provide information to the ATP on: claim approval, claim decline decision (not reasoning behind decision), claim wait periods, any claim information requested and/or payment amounts and schedule of payments.

You must ensure the ATP is aware of our Privacy Policy and agrees to their personal information being collected, used and disclosed accordingly. Our Privacy Policy can be found at www.hallmarkinsurance.com.au.

My personal details.

Name: _____

Signed by: _____ Date: / /

My authorised person's details.

Name: _____

Address: _____

_____

_____

Date of birth: / / Relationship with person named above: _____

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Insured to pass to employer and return.
Alternatively provide a letter from employer.

Employers Section

1. Employees full name

2. Occupation

3. Date employment commenced: / /

4. Number of hours worked pw

5. Date last worked: / /

6. Reason employee ceased work?

7. If the employee has ceased work due to an accident, have the details been reported via the normal channels? ☐ Yes ☐ No

8. Has the employee previously suffered from this injury or sickness whilst working for you ☐ Yes ☐ No
If yes, please provide details and dates:

Condition	Date from	Date to
	/ /	/ /

9. Is the employee still in your employment? ☐ Yes ☐ No

10. If no, please provide reasons for leaving and last date of employment

Signature ✗

Date (dd/mm/yy) / /

Name

Position

Name and address of Employer

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Hallmark General Insurance Company Ltd ABN 82 008 477 647 AFSL 243478 (collectively "Hallmark Insurance")
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Left blank intentionally to allow separation of the sections to pass onto the relevant third party.
Can be used to write additional information

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INITIAL ACCIDENT AND SICKNESS CLAIM FORM

DOCTOR'S SECTION – Insured to pass to Doctor and return.
Alternatively provide medical certification or other report relating to the claimed condition.

- All questions must be completed by a medical practitioner.
- Any costs associated with the completion of this form are to be met by the patient.
- Please complete and return to the patient.
- A copy of this statement and any other report you provide may be passed to other parties reasonably deemed necessary for the assessment of the patient's claim.

Patient's Name:

Date of Birth (dd/mm/yy): / /

Residential Address:

Suburb/Town: State: Postcode:

Date you last examined the patient (dd/mm/yy): / /

1. How long has this patient been attending this medical practice (when did the records commence)?

2. When did the patient first consult you for this condition?

3a. What is the Primary Diagnoses/condition restricting the patient returning to work?

Is this diagnosis defined as any of the following?

Heart attack ☐ Major organ transplant ☐ Cancer ☐

Kidney failure ☐ Coronary artery disease requiring surgery ☐ Stroke ☐

3b. Date Primary Condition Diagnosed ..... / /

4. Is there a secondary Condition / Diagnosis impacting the patients ability to work?

5a. Date your patient became unfit for work due to the diagnosis? ..... / /

5b. What date is the patient certified until? ..... / /

6. Please list and describe the current symptoms and severity

7. What is your understanding of how the condition arose?

8. What are the predisposing causal factors (if any) associated with the patient's condition

9. Is your patient totally incapacitated and unable to perform their usual occupational duties due to their condition?

☐ Yes ☐ No ☐ Unknown

10. When do you anticipate your patient will be able to return to work? / / ☐ Unknown

11. Has your patient previously consulted you or any other Doctor with symptoms of this or any other similar condition?
If yes please provide details

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12. What is the current treatment/proposed treatment?

13. If hospitalised please advise dates from / / to / /

14. Have you refered the patient to a specialist ☐ Yes ☐ No

If yes - please provide details

Additional Details/Comments

Declaration

I certify I have personally attended the above patient and that all the information supplied by me on this patient is true and correct to the best of my knowledge and belief.

Signature of Doctor ✗ Date (dd/mm/yy) / /

Name

Qualifications

Surgery Address

Suburb/Town State: Postcode:

Phone Fax:

Email Address