HALLMARK INSURANCE

ONGOING ACCIDENT AND SICKNESS CLAIM FORM

Please complete this claim form and return to:

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

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

IMPORTANT INFORMATION

1. The issue of this claim form is not an admission of liability
2. It is a condition of your policy that you provide a fully completed claim form as quickly as possible (within 120 days of the claim commencement date). A delay in submitting this form may prejudice your entitlement to a claim.
3. Please ensure that all questions are fully answered to avoid any delay in the handling of your claim.
4. If you do not complete all relevant sections of your claim form we may have to return it to you to be fully completed and your claim may be delayed.
5. It may be necessary during the period of your claim for a company representative to call you.
6. It is important that you notify us of any change in circumstances during your claim at the earliest opportunity.
7. If there is not enough room within the form to provide your responses please attach any documentation/word document that will aid us in assessing your claim.

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Insured to complete

Details of Insured

1. Claim Number _____
2. Date of Birth (dd/mm/yy): / /
3. Surname:
4. First Names:
5. Residential Address:
6. Suburb/Town:
7. Phone: Home: Mobile:
8. Email:

Medical Details

9. Have your symptoms changes since your last claim form was completed? ..... ☐ Yes ☐ No
If yes, please provide details below.

10. How do your current symptoms impact your ability to perform your occupational duties?

11. Since your last claim form, have you consulted any medical practitioner and/or allied health professional? ..... ☐ Yes ☐ No
If yes, please provide details.

12. Is your current treatment providing relief of your symptoms? ..... ☐ Yes ☐ No
If no, has a change in your treatment been discussed with your Doctor, please provide details/outcome of any discussion:

13. Have you returned to any paid or unpaid work? ..... ☐ Yes ☐ No

If yes, when: Part-time (dd/mm/yy) / / Full Time (dd/mm/yy) / /

Please detail the duties performed and hours worked per week
(e.g. computer work)

% of time performing duties eg 55%

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14. Other Information

Are you making any other insurance claims in respect of this period of disability? ..... ☐ Yes ☐ No

If yes, please provide the name of the insurer and contact details

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 1800 800 230 or customerservice@hallmarkinsurance.com.au during normal business hours (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			

Left blank intentionally.

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Medical Practitioner to complete

- 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): / /

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

1. What is the current diagnosis and has it changed in any way since the last claim form was completed?

2. What are the current subjective symptoms reported by your patient and severity of each symptom (e.g. mild, moderate or severe)?

3. On examination what are the patient's current objective symptoms?

4. What treatment (medication, doses and other therapies) is currently being provided?

5. Are you coordinating the treatment/management plan? ..... ☐ Yes ☐ No

If **no**, please provide details of the treatment coordinator.

6. Has the patient undergone any test or investigations since the last claim form? ..... ☐ Yes ☐ No

If **yes**, please provide copies of all test results.

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7. Is the current treatment providing any relief of symptoms? ☐ Yes ☐ No

If **no**, what future treatment/management plans are there for your patient?

8. Has the expected duration of disability exceeded the initial prognosis? ☐ Yes ☐ No

If **yes**, please provide the reasons for this extension of the duration of disability.

9. a) Is your patient still unfit for work: if yes date from / / to / /

b) If totally disabled please list the occupational duties that the patient is unable to perfom.

10. Is the patient currently able to perform their usual occupational duties? ☐ Yes ☐ No

If **yes**, on what date was the patient able to perform their usual occupational duties?

Part-time (dd/mm/yy) / / Full Time (dd/mm/yy) / /

Hours able to work per week

If only **Part Time**, please list the specific usual occupational duties the patient is currently able to perform.

Duties	**Hours per week**
Total hours per week	

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11. Have you, or are you, completing forms or reports for any other organisation (e.g. insurance company, Workers' Compensation Insurer, Motor Accident compensation, Centrelink or any other litigation claim) or the employer in respect of the patient? ..... ☐ Yes ☐ No

If **yes**, please provide details.

Additional Details/Comments

Declaration

I hereby 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)	/ /
Doctor Name			
Qualifications			
Surgery Address			
Suburb/Town		State:	Postcode:
Phone		Fax:	
Email Address			

Left blank intentionally.