QUEENSLAND COUNCIL OF UNIONS
PERSONAL ACCIDENT AND SICKNESS CLAIM FORM

This claim form consists of 3 parts and all sections must be completed in full.

Section A Claimant Statement – The claimant is to complete all questions in this section.

Section B Doctor Statement – The treating doctor must complete Section B after completing Section A and we do not hold any responsibility for any charges.

Section C Employer Statement –Must be completed by the claimant's employer.

Important information

1. A claim cannot be assessed until we receive all sections of the original completed claim form.
2. To have a valid claim, you must be medically disabled from work for at least the waiting period **(21 Days).**
3. Incomplete questions may delay the assessment process and the claim form could be sent back to be completed.
4. All original medical certificates must be provided (please note in order to have a valid medical certificate it must state the medical condition and period disabling the claimant from returning to work).
5. A full 12 month wage report prior to the disablement is required to be provided with Section C to determine the benefit amount.
6. All claim payments will be sent to your employer.

Please forward the completed claim form to: **Attention: Claims Department**
Windsor Income Protection
PO Box 3651
Rhodes NSW 2138

If you have any questions, please don't hesitate to contact our claims department on **1300 547 966**

Section A – Claimant Statement

Claimant's Details

Given name		**Surname**		**Title**	
Address					
Suburb		**State**		**Postcode**	
Home phone		**Mobile**			
Fax		**Gender**	☐ M ☐ F	**Date of Birth**	/ /
Email				**Height**	Cm **Weight** Kg
Name of Union (if applicable)				**Member No.**	

Employment Details

Employer name					
Manager's name					
Street Address					
Suburb		**State**		**Postcode**	
Work phone		**Work fax**			
Date you commenced employment	/ /				
Occupation at the time of disablement					
Describe your usual duties					
Are you still employed?	☐ Yes ☐ No	**If No, when did you cease employment?**	/ /		

Are you self-employed?	☐ Yes ☐ No

Bank Details

Name of financial institution			
Name on account			
BSB number		Account No.	

Medical Details

Is your condition an	☐ Injury OR ☐ Sickness
Description of Injury or Sickness	
If your condition is an Injury, please state exactly how, when and where it occurred	
When did symptoms first occur for your medical condition?	Date: / / Time: :
When did you first consult a doctor for this medical condition?	Date: / /
When was your last day at work as a result of this condition?	Date: / /
Have you returned to work?	☐ Yes ☐ No
If Yes, please provide the date you returned / /	If No, please advise the date you expect to return / /
In your opinion, do you believe your condition is work related?	☐ Yes ☐ No
In your opinion, do you believe your condition is a result of playing sports?	☐ Yes ☐ No
Is or was surgery required for your condition?	☐ Yes ☐ No If Yes, when was/is surgery? / /
Have you had a similar condition in the past?	☐ Yes ☐ No

If Yes, please complete the details below for the physician/specialist you attended.

DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED
			/ /

Medical Practitioner Details (please give a history for over 5 years)

If you've attended more than 2 medical practitioners over the past 5 years, please attach a list with the claim form, please note if a complete medical history is not provided, your claim maybe delayed while we obtain a full Medicare history

Doctors name		Practice/Hospital			
Address					
Suburb		State		Postcode	
Phone number		Fax number			
Date first attended	/ /	Date last attended	/ /	Years attended	
Doctors name		Practice/Hospital			
Address					
Suburb		State		Postcode	
Phone number		Fax number			

Date first attended	/ /	Date last attended	/ /	Years attended	

Other Benefit Details

Question	Yes	No
Have you or are you planning to lodge motor accident compensation claim?	☐ Yes	☐ No
Have you or are you planning to lodge a sports insurance claim?	☐ Yes	☐ No
Have you or are you planning to lodge a Workers Compensation claim?	☐ Yes	☐ No
Have you or are you planning to lodge a claim with any government benefits?	☐ Yes	☐ No
Are you making or entitled to lodge a claim with any other insurer or compensation benefit?	☐ Yes	☐ No

If you have answered Yes to any of the above, please complete the below and provide details of your claim. For example an acceptance or decline letter and copies of any benefits.

Insurer/Company name			
Type of claim			
Address			
Contact person		Contact No.	

Have you or are you planning to receive any employer benefit? Sick leave etc.	☐ Ye s	☐ No

Authorised Representative's (this section is optional)

Complete this section if you wish to authorise a family member or friend to assist you with the claims process, as it is required to disclose any personal information about your claim which includes medical, financial, employment and insurance information.

Name of authorised representative			
Representative's relationship to you		Representative's date of birth	/ /

Declaration & Authorisation

Privacy Statement

In this statement "we", "us" and "our" means Lloyd's and Windsor Income Protection as its agent.

We are bound by the obligations of the Privacy Act 1988 as amended by the Privacy Amendment (Enhancing Privacy Protection) Act 2012. This sets out basic standards relating to the collection, use, storage and disclosure of personal information.

Our Privacy Policy, available at www.windsorip.com.au or by calling us, sets out how:

- **we protect your personal information;**
- **you may access your personal information;**
- **you may correct your personal information held by us;**
- **you may complain about a breach of the Privacy Principles or Registered Privacy Code and how we will deal with such a complaint.**

We, and our agents, need to collect, use and disclose your personal information in order to consider your application for insurance and to provide the cover you have chosen, administer the insurance and assess any claim. You can choose not to provide us with some of the details or all of your personal information, but this may affect our ability to provide the cover, administer the insurance or assess a claim.

We may disclose your personal information to third parties who assist us in providing the above services. These parties (which include our related entities, distributors, agents, insurers (including reinsurers) and service providers) will only use the personal information for the purposes we provided it to them for (unless otherwise required by law). Some of these parties may be located outside of Australia which includes but is not limited to the United Kingdom.

Information will be obtained from individuals directly where possible and practicable to do so. Sometimes it may be collected indirectly (e.g. from your representatives or co-insureds). If you provide information for another person you represent to us that:

- **you have the authority from them to do so and it is as if they provided it to us;**
- **you have made them aware that you will or may provide their personal information to us, the types of third parties we may provide it to, the relevant purposes we and the third parties we disclose it to will use it for, and how they can access it. If it is sensitive information we rely on you to have obtained their consent on these matters. If you have not done or will not do either of these things, you must tell us before you provide the relevant information.**

You are entitled to access your information if you wish and request correction if required. You may also opt out of receiving materials sent by us by contacting Windsor Income Protection on
1300 547 966 or via email at info@windsorip.com.au.

1. **I hereby authorise Windsor Income Protection to disclose my personal information to any of the following parties: any authorised representative of Windsor Income Protection, my authorised representatives, Queensland Council of Unions and any physician, hospital, healthcare provider who has attended or examined me in order for Windsor Income Protection to be supplied with my full medical history including but not limited to any medical or hospital records, reports, clinical notes and referral letters.**

2. **I hereby authorise and consent to Windsor Income Protection to collect any information for the assessment of my claim from any of the following: Queensland Council of Unions, employer(s), workers compensation insurer, insurance company, government department (which includes Centrelink or similar benefit providers), claims assessor, legal firm, physician, hospital, healthcare provider who has attended or examined me in order for Windsor Income Protection to be able to be supplied with my full medical history including but not limited to any medical or hospital records, reports, clinical notes and referral letters.**

3. **I hereby declare that all information that I've supplied is true and correct in every aspect. I have not made any false or misleading statements.**

4. **I do understand that this claim and any future claims may be refused if any information I've provided is not true, misleading or relevant information has been withheld.**

5. **A photocopy, emailed and fax copy of this authority is considered as effective and valid as the original.**

Name (please print)			
Signature		**Date**	/ /

Section B – Doctor's Statement (must be completed by your regular treating doctor)

*Please note any and all charges for the completion of this form, is the full responsibility of the patient.

Patient's Details

Patient's given name		Surname			
Patient's address					
Suburb		State		Postcode	
Gender	☐ Male ☐ Female	Date of birth	/ /	Age	

Are you the patient's regular doctor?	☐ Yes ☐ No
How long has this patient been attending your practice/hospital?	Years Months
The medical condition currently disabling the patient from work is a	☐ Injury OR ☐ Sickness
When did the patient first attend your practice for the current condition?	/ /
What date did the patient's symptoms first appear or injuries occur?	/ /
When was the patient diagnosed?	/ /
What date was the patient incapacitated from work for this condition?	/ /

For this condition, please list all dates the patient attended your practice/hospital for treatment and advice.

1. / /	2. / /	3. / /	4. / /	5. / /
6. / /	7. / /	8. / /	9. / /	10. / /
11. / /	12. / /	13. / /	14. / /	15. / /

Please state the primary medical diagnosis disabling the patient	
If any, please list all other medical condition affecting a return to work	
What is the cause of the patient's current disablement?	
Please provide details of the patient's symptoms	
Please advise the prescribed medication & treatment given to the patient	
Are there any complication regarding the patient's recovery?	☐ Yes ☐ No
If Yes, please give details.	
Has the patient had a similar condition in the past?	☐ Yes ☐ No

If Yes, please give details below of the similar condition, time of onset and contact details of the physician/specialist attended for that condition.

Medical condition was…. Onset of the condition occurred in….

DOCTOR'S NAME	PRACTICE/HOSPITAL NAME	CONTACT NUMBER	DATE ATTENDED
			/ /

In your professional opinion, do you believe this condition is work related?	☐ Yes ☐ No
In your professional opinion, do you believe this condition is sports related?	☐ Yes ☐ No
Has the patient been following your prescribed medication and treatment?	☐ Yes ☐ No
If No, give details of when the patient did not follow the medical advice.	
Have you advised the patient that their condition no longer requires any treatment or advice?	☐ Yes ☐ No
If Yes, please advise the date you gave this advice to the patient	/ /
In regards to the patient's medical condition, have you issued any certificates or forms to any other insurance companies, workers compensation or government benefit entities?	☐ Yes ☐ No
If Yes, please advise to which company.	
In your opinion, does the patient require surgery for this condition?	☐ Yes ☐ No
If Yes, has surgery been undertaken?	☐ Yes ☐ No Please advise the date of surgery? / /
Has the patient been referred to a specialist for the condition?	☐ Yes ☐ No
If Yes, please give contact details.	
In your professional opinion, when do you believe the patient will be fit to return to work on alternative duties?	/ /
In your professional opinion, when do you believe the patient will be fit to return to work for full duties?	/ /
Please comment on the patient's current prognosis?	
I certify the above patient was/is totally disabled from returning to work for the period	/ / TO / /
I certify the above patient was/is partially disabled from returning to work for the period	/ / TO / /

Doctor's Declaration and Authority

I hereby certify that I am a registered medical practitioner and have examined the above named patient and that all information that I've supplied is true and correct. I also acknowledge that Windsor Income Protection may provide copies of these forms to any required representative and or third parties deemed necessary to assist the ongoing assessment of the claim.

Practice/Hospital name					
Name (please print)					
Address					
Suburb		State		Postcode	
Phone number		Fax number			
Email					
Medical qualifications					
Signature		Date	/ /		

Section C – Employer's Statement

*Please provide attached a full 12 month wage report prior to the disablement as this is required to determine the benefit amount.

Employee's Details

Employee's name		Employee's number	
Employee's occupation			
Description of Injury or Sickness			

Employment type	☐ Full-Time ☐ Part-Time ☐ Casual ☐ Contractor ☐ Self-Employed
Current work status	☐ Employed ☐ Resigned / / ☐ Terminated / /

Date commenced employment	/ /	Date of Injury or Sickness	/ /
Date last actively at work	/ /	Date incapacity commenced	/ /
Was the employee on alternative duties prior to the incapacity date?	☐ Yes ☐ No If Yes, from when? / /		
Expected return to work date	/ /	Employee's gross weekly earnings	$

Question	Answer
Has the employee salary sacrificed any wages in the past 12 months? If yes, please provide evidence.	☐ Yes ☐ No
If the employee is fit for alternative duties are you prepared to take the employee back on alternative duties?	☐ Yes ☐ No
In respect of this condition has your company completed any forms to any other insurance companies, workers compensation insurer or government benefit entities?	☐ Yes ☐ No
If Yes, please advise when and to which company	
Has the employee received any employer entitlements (normal pay, sick leave, annual leave etc.) since the incapacity commenced, if Yes please complete details below?	☐ Yes ☐ No

TYPE OF EMPLOYER BENEFIT	AMOUNT RECEIVED	DATE RECEIVED FORM	DATE RECEIVED TO
	$	/ /	/ /
	$	/ /	/ /

Question	Answer
Do you believe the employee's condition is work related?	☐ Yes ☐ No
Is your company self-insured for workers compensation?	☐ Yes ☐ No
Is the employee currently on workers compensation?	☐ Yes ☐ No
Does your company top-up workers compensation claims?	☐ Yes ☐ No

Name of Workers Compensation		Policy No.	

Employer's Declaration and Authority

I hereby certify I'm authorised to answer the above on behalf of the employer & all information I've supplied is true & correct. I acknowledge Windsor Income Protection may provide these forms to required representative or third parties necessary to assist the ongoing assessment of the claim.

Company name					
Manager/Supervisor name		Job title			
Address					
Suburb		State		Postcode	
Phone number		Fax No.			
Email					
Signature		Date	/ /		