Disablement Claim Form

Sovereign Insurance Australia Pty Ltd

ABN 85 138 079 286

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IMPORTANT NOTES TO THE INSURED

Sovereign Insurance Australia Pty Ltd collects personal information from you for the purpose of providing you with insurance products and services, including processing and assessing your claims. We will not use your personal information for direct marketing purposes unless we obtain your prior consent. You can choose not to provide this information; however, we may not be able to process your request. We may disclose information we hold about you to our related companies, other insurers, an insurance reference service or as required by the law. In the event of a claim, we may disclose information to, and/or collect additional information about you from, investigators or legal advisors. If you wish to update or access the information we hold about you or if you would like more information about our Privacy Policy, please contact our office.

Your Personal Details

Name

Date of Birth

Address

Post Code

Phone No

Financier

Contract No

Date policy commenced

Fortnightly/Monthly Installments

$

Policy No

Occupation at time of disability

Your usual occupation

Current employer

Date employed from

Date employed to

Address

Post Code

Telephone No

Employer at policy commencement date

Address

Post Code

Telephone No

Are you claiming workers compensation?

Yes ☐ No ☐ If yes, insurer

About your Disability

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Date on which the illness or injury first occurred

Time

AM/PM

What was your last working day

Please give explanation of your current disability

Was the injury caused by a motor vehicle accident? Yes ☐ No ☐

Police attended? Yes ☐ No ☐

Who is your usual doctor?

For how long

Years

Months

Your doctor's address

Telephone No

Please state names and addresses of all doctors and hospitals consulted by you for this current disability

Name

Telephone No

Address

Name

Telephone No

Address

Name

Telephone No

Address

I resumed my work duties on

Or I expect to be fit for some work duties by

Your Medical History

1. Have you previously suffered from this injury or illness? Yes ☐ No ☐ If YES provide details

Name of doctor

Telephone No

Address

Date(s) of consultation (1) (2)

Nature of complaint

Period of disability from to

2. Have you previously suffered any OTHER major illness/injury unrelated to this disability? Yes ☐ No ☐

If YES provide details

Complaint

Date of occurrence

Period of disability (Years/Months/Days)

3. Do you take regular medication for any illness or injury? Yes ☐ No ☐

If YES provide details

Date

Claims History

Have you ever submitted any previous claims for injury or illness? Yes ☐ No ☐

If YES name of finance company

Telephone No

Date

Declaration

I hereby declare that:

(1) I am the person insured by this policy and referred to in the foregoing particulars.

(2) The above statements and answers are correct and true and, I acknowledge responsibility for their completeness and accuracy, whether the answers have been written by me or by any other person on my behalf.

(3) I am fully aware and agree that any false statements and particulars made by me on this form or any further declarations will result in my claim being denied.

(4) I authorise any hospital, institution or medical practitioner who has treated or examined me or any person or firm who has employed me, or any firm through which I have claimed compensation to provide Sovereign Insurance Australia Pty Ltd any information it may request in respect of any trauma, illness, injury, medical history, treatment or advice received by me. A photocopy of this authority can be acted upon as if it were the original.

(5) I authorise my financier to provide Sovereign Insurance Australia Pty Ltd with details of my loan for administration of this claim.

Signature of insured

Signature of witness

Date

Medical Certificate

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IMPORTANT NOTE

This certificate must be completed by the qualified and registered Medical Practitioner treating you for your current disablement. In the event of the Medical Practitioner being unable to answer, from personal knowledge, any of the following questions, this must be stated. The Certificate is to be completed at the insured's expense and forwarded by the Medical Practitioner to Sovereign Insurance Australia Pty Ltd at the earliest opportunity.

Please PRINT ALL information

Name of attending Doctor

Telephone No

Patient's Name

Date of Birth

Occupation

Are you the insured's usual Doctor? Yes ☐ No ☐

For how long? Years Months

State nature and cause of Disablement

When did you first treat the claimant for this illness or injury

Please provide details of treatment

Please provide details of any medication

Are there any medical conditions which have a bearing on this current disablement? Yes ☐ No ☐

If yes, please explain

Has the insured ever received a medical diagnosis, treatment, operation or attention for a similar disablement or related cause? Yes ☐ No ☐

Please supply the following details: (provide on a separate page if insufficient space)

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Date	Nature of disability	Date	Nature of disability

Date	Nature of disability	Date	Nature of disability

Date	Nature of disability	Date	Nature of disability

If not by yourself, name and address of Doctor

What is your prognosis?

Please provide details of operation(s) if any, and date(s)

Have you any reason to: Suspect that the insured's disablement has resulted from or been contributed to by the influence of intoxicating liquor or drugs? Yes ☐ No ☐

Has the insured been **totally disabled** from performing:

(1) Any occupation? Yes ☐ No ☐

(2) Each and every duty pertaining to his or her usual occupation

Yes ☐ No ☐ Period from ______ to ______

(3) Is the insured capable of performing light or limited duties?

Yes ☐ No ☐ Period from ______ to ______

If total disablement still exists, on what date is it likely to cease?

Signature of Medical Practitioner | Date

Qualifications | Telephone No

Address of practice

PLEASE ENSURE YOU COMPLETE ALL QUESTIONS, IF NOT THE PROCESSING OF YOUR CLAIM MAY BE DELAYED.

AN ORIGINAL OF THE CLAIM FORM IS REQUIRED FOR ASSESSMENT.

Please email to: claims@sovereignaustralia.com.au

or post to: Sovereign Insurance Australia Pty Ltd

PO Box 4301, Loganholme QLD 4129 | Phone: 1800 240 125