CHUBB®

Polocrosse Association of Australia

Personal Accident Claim Form

This cover sheet has been prepared to assist members of the Polocrosse Association of Australia (PAA) to provide information which is important to process any accident insurance claim as quickly as possible.

Please ensure that all relevant sections of this claim form are fully completed. The insurer, Chubb Insurance Australia Limited (Chubb), may be unable to consider assessment of your claim unless all information has been provided. Failure to provide all information may result in delay in the processing and assessment of your claim.

Please note: the issue and acceptance of this form does not constitute an admission of liability by Chubb or a waiver of its rights.

If further information is required, you will be contacted directly by the insurer, Chubb. If you have any questions about the claim process, the appointed broker for the PAA is Marsh Advantage Insurance Pty Ltd. The PAA contact at Marsh, Mark Holmes, can be contacted on 08 8385 3612 for assistance.

The PAA website includes a downloadable brochure summarising the benefits payable and claims process visit www.polocrosse.org.au to access this.

Tick when completed	
1. **Fully** complete pages 1, 2, 3 and 4.	☐ Yes
2. Ensure you sign the declaration in **General Particulars** on Page 4.	☐ Yes
3. Ensure you sign the **Authority to Give Information** on Page 4.	☐ Yes
4. Have your Doctor or treating physician complete and sign Pages 5 and 6.	☐ Yes
5. **Ensure** you have an initial medical certificate, showing the likely date of return to work. If you remain incapacitated when the initial certificate expires, you will need to consult again with your Doctor to obtain a continuing certificate. Please provide to your State Association Office or the Insurer directly.	☐ Yes
6. For weekly payments, you will need to supply evidence of earnings from your own personal exertion, not including investments etc, for the 12 months prior to your injury.	☐ Yes
7. If you wish to be paid weekly benefits by Electronic Funds Transfer, complete the Bank Details form, Page 5.	☐ Yes
8. Send completed form and supporting documentation to your State Polocrosse Association Office as soon as possible when your membership will be verified.	☐ Yes
This cover sheet has been prepared to assist members provide the information which is important to process any accident insurance claim as quickly as possible.	

Polocrosse Association of Australia Personal Accident Claim Form

Please send this completed form and all documentation to:

Chubb Insurance Australia Limited
Accident & Health Claims, GPO Box 4065 Sydney NSW 2001
O 1300 722 032 Claims
O 1800 815 675 Customer Service
E a&hclaims.au@chubb.com

Notice in writing of the claim must be sent to the company within 30 days from its occurrence, or the claim may not be recognised. Please complete this form and return it to Chubb within that time period.

Section 1 - Your Information

Policy No.					
PAA Membership No.					
Surname					
First Name				Title e.g. Mrs	
Address					
				Postcode	
Email Address					
Date of Birth			Sex (M/F)		
Marital Status			Dependants		
Place of Birth			Occupation		
Telephone (Home)		(Business)		(Mobile)	
Employer's Name			Telephone No		
Address					
				Postcode	
Were you employed at the time of suffering the accident?					☐Yes ☐No
If No, provide full details:					

Was your employment	☐Full time ☐Part time ☐Temporary	Length of Service	

Section 2 - Accident

Location where accident occurred				
Date of Accident		Time		☐am ☐pm
What were you doing?				
How did it occur?				

Nature and extent of injuries:

Have you ever previously suffered from this type or a similar type of injury?	☐ Yes ☐ No
If Yes, provide full details:	

Section 3 - Period Off Work

Please provide the date and time of your first medical consultation for this Accident/Sickness:

Date		Time		☐ am ☐ pm
On what date did you last work?				
Have you been able, since the Accident/Sickness occurred, to attend in any way to your business/employment or any portion of it?				☐ Yes ☐ No
If Yes, provide full details:				

Have you been able to engage in any other occupation following your Accident/Sickness?	☐ Yes ☐ No
If Yes, provide full details:	

I am now disabled	☐ Wholly ☐ Partially ☐ Not at all		
On what date did you return to work?			
If still disabled, state how much longer disability is likely to continue		☐ Weeks ☐ Months	☐ Permanent

Name and Address of Medical Practitioner who attended this condition:

Name			
Address			
		Postcode	

Name and Address of your regular Medical Practitioner:

Name			
Address			
		Postcode	

Section 4 - Previous Medical History

What other medical or surgical advice, treatment or attention have you received during the past five years? (Give dates, nature of injury or sickness and names and addresses of all doctors, hospitals and clinics). Please answer fully - dashes are not acceptable.

Date	Nature of Injury or Sickness	Names	Address

Section 5 – General Particulars

Are you insured elsewhere for Accident or Sickness?				☐ Yes ☐ No
If Yes, provide Name and Address of Insurer:				
Name				
Address				
		Postcode		
Do you hold Private Health Insurance?				☐ Yes ☐ No
If Yes, which Insurer				
Have you lodged a claim under Work Cover/Workers Compensation/Compulsory Third Party insurance or are you eligible to lodge a claim under Work Cover/Workers Compensation/Compulsory Third Party insurance?				☐ Yes ☐ No
If Yes, provide Name and Address of Insurer:				
Name				
Address				
		Postcode		
Claim Number		Status of Claim		
Are you entitled to sick leave?				☐ Yes ☐ No
If Yes, please advise number of days		or Period you have received sick leave. From		To

If you are claiming weekly benefits:
Please provide your gross basic salary (excluding bonuses, commission, over-time payments and other allowances) averaged over the calendar year immediately preceding injury/sickness.

Note: A copy of your last three (3) payslips prior to date of injury/illness or tax statement for the last financial year will also be required.

Section 6 – Declaration (to be signed by the claimant)

I hereby declare that I am suffering or have suffered from the injury or sickness above named and warrant the truth of the foregoing particulars in every respect, and I agree that if I have made or shall make any false or untrue statement, suppression or concealment, my right to compensation could be forfeited.

Signature of Claimant			
Address			
		Postcode	
Date			

Section 7 – Payment Details

Electronic Funds Transfer			☐ Yes ☐ No
Account Name	☐ Mr ☐ Mrs ☐ Ms ☐ Miss		
Account Number			
Bank Name			
Bank Address			
BSB Number			
Swift Code (For International Transfers)			

Cheque				☐ Yes ☐ No
Name of Payee	☐ Mr ☐ Mrs ☐ Ms ☐ Miss			
Street Address				
Suburb/Town				
State		Postcode		

Section 8 – Medical Certificate/Certificate of Attending Physician
(Please note: this section is required to be completed by the attending Physician)

The claimant must obtain, at their own expense, the completion of this certificate from a duly qualified and registered medical practitioner. In the event of the medical practitioner being unable to answer from his own personal knowledge any of the following questions, he is requested to state so.

Furnished in connection with the disability of:

Name of Patient			
Address			
		Postcode	
Are you the patient's regular physician?			☐ Yes ☐ No
If Yes, how long have you known the patient?	Years	Months	
Diagnosis of Illness/Injury			
Complications			
Has the patient previously suffered from the same or similar injury/sickness? If yes, provide the date and diagnosis:			☐ Yes ☐ No
Date		Diagnosis	
Date of first consultation for this condition			
How long has this condition, in your opinion, been in existence whether treated for same or not?			

Present Condition				
Prognosis				
Nature of Operation (if any)				
Name of Physicians who previously treated patient for above condition				
Name				
Name				
Are the patient's symptoms	☐ due exclusively to the accident	☐ or traceable to disease	☐ infirmity or any other cause	
Is there anything in the patient's medical history which may have contributed, directly or indirectly, to the injury/illness or which may be likely to retard the patient's recovery?				

Is patient still under your care for this condition?				☐ Yes ☐ No
If not, on what date did you release patient to perform regular duties				
Dates totally unfit for work (unable to perform specific parts of the patient's occupation):				
From		To		Both dates inclusive

Dates partially unfit for work (unable to perform specific parts of the patient's occupation):					
From		To		Both dates inclusive	
If uncertain, please estimate:	Totally Unfit to (date)		Partially Unfit to (date)		
Have you any reason to suppose that the patient was under the influence of Intoxicants or drugs at the time of the accident?				☐ Yes ☐ No	
If hospitalised, give dates:	From		To		
Name of Hospital					
Give dates patient was totally disabled:	From		To		
In your opinion, probable further disability should not exceed	☐ Weeks ☐ Months	From			
Name of Physician					
Address					
		Postcode			
Phone Number					
Qualifications					
Signature					
Date					

Section 9 - State Polocrosse Association Administrator Certification

This page of the Claim Form needs to be completed by a State Association Administration Officer

1. Name of Injured Person			
was injured as stated whilst participating in			
Event at the			Club
2. Name of Home Club		State	
3. Address of Club			
4. On what date did the injured person sustain the injury?			
5. Was the activity in which the injured person of the organisation was participating; at the time of injury, an officially authorised and sanctioned activity of the insured organisation			☐ Yes ☐ No

Declaration:

I:	full name	am the	title of office bearer

declare that the information provided in this certification is true, correct and completed to the best of my knowledge and ability.

Signed	
Dated	

Section 10 - Privacy and Claim Declaration

Provision of Health Insurance
Chubb cannot provide cover or benefits under Medicare or private health insurance laws or regulations in Australia including the Health Insurance Act 1973 (Cth), Private Health Insurance Act 2007 (Cth) and Private Health Insurance (Health Insurance Business) Rules 2010 or any successor legislation.

Claim Privacy Consent
Chubb Insurance Australia Limited (Chubb) is committed to protecting your privacy. Chubb collects, uses and handles your personal information only in accordance with the Privacy Act 1988 (Cth) (Privacy Act). A copy of our Privacy Policy is available on our website at www.chubb.com/au or by contacting our customer relations team on 1800 815 675.

Your personal information will be used by Chubb, or any third party that Chubb provides the information to, for the purpose of assessing your claim or your entitlement to benefits and, if the claim is accepted, for administration of the claim and for planning, product development and research purposes.

Your personal information may include:
a) any information provided in relation to your claim;
b) any information that is health information or sensitive information, including, without limitation, your medical history, any treatment received by you and any medication taken or prescribed for you (at any time) or your Health Insurance claims history, including Medicare;
c) any other personal information that you may provide to Chubb or its third party contractors;
d) any information relating to any insurance policy on your life, including terms and conditions and claims history;
e) details of your employment including position, period of employment, remuneration, hours worked and duties performed (at any time); and
f) any other information relating to your income, assets, liabilities and solvency; and
g) any information from third persons who may have information relevant to your eligibility to receive a benefit, or your entitlement to receive an ongoing benefit.

To assess and process your claim Chubb may need to collect your personal information from third parties such as your insurance broker, claims reference services, government organisations (for example, social security agencies or taxation offices), your doctor or other health service provider, any forensic accountant or investigator retained by Chubb, your employers (past and present), your accountant and any businesses which provide information about the commercial activities of persons or, if you are, or have been, bankrupt the trustee of your estate (the 'Parties').

Chubb may disclose your personal information, including health and sensitive information, to other entities within the Chubb group, other insurers, our reinsurers or third parties, including contractors and contracted service providers (such as assessors or investigators) who we, or those other Chubb Group entities, have engaged to provide a specific service. Those entities may be located overseas, for example the regional head offices of Chubb in Singapore, UK or USA or third parties with whom we or those other Chubb Group entities have subcontracted to provide a specific service for us, which may be located outside of Australia (such as in the Philippines or USA).

Chubb may also disclose your personal information to witnesses in respect to your claim and to government agencies including the police (where we are compelled to by law).

If you do not consent to the terms of this Privacy Consent and Medical Authority or revoke your consent, Chubb may not be able to process or assess your claim.

If you would like to access a copy of your personal information, or to correct or update your personal information, please contact our customer relations team on 1800 815 675 or email CustomerService.AUNZ@chubb.com.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proofs of my claim, Chubb has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to Chubb using and disclosing my personal information pursuant to Chubb's Privacy Policy and this document. In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to Chubb's privacy officer.

I authorise any person or entity, including but not limited to the Parties referred to above, to provide to Chubb such personal information (including health information) as Chubb in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits. I will use my best endeavours and render all reasonable assistance and co-operation to Chubb in the assessment of my claim. I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim. I understand that my claim may be denied if the information supplied is untrue, or I have not revealed all relevant facts.

I appoint Chubb to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature	
Date	

About Chubb in Australia

Chubb is the world's largest publicly traded property and casualty insurance company. With operations in 54 countries, Chubb provides commercial and personal property and casualty insurance, personal accident and supplemental health insurance, reinsurance and life insurance to a diverse group of clients. As an underwriting company, we assess, assume and manage risk with insight and discipline. We service and pay our claims fairly and promptly. The company is also defined by its extensive product and service offerings, broad distribution capabilities, exceptional financial strength and local operations globally. Parent company Chubb Limited is listed on the New York Stock Exchange (NYSE: CB) and is a component of the S&P 500 index. Chubb maintains executive offices in Zurich, New York, London and other locations, and employs approximately 31,000 people worldwide.

Chubb, via acquisitions by its predecessor companies, has been present in Australia for over 50 years. Its operation in Australia (Chubb Insurance Australia Limited) provides specialised and customised coverages, including Marine, Property, Liability, Energy, Professional Indemnity, Directors & Officers, Financial Lines, Utilities, as well as Accident & Health insurance, to a broad client base. Chubb is a major insurer of many of the country's largest companies. With five branches and over 500 staff in Australia, it has a wealth of local expertise backed by its global reach and breadth of resources.

More information can be found at www.chubb.com/au

Contact Us

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Chubb. Insured.[SM]

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