Claim Form

CORPORATE
SERVICES
NETWORK

Liberty
Specialty Markets

VOLUNTARY WORKER

Important Notice

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. This form can be completed electronically. If completing this form by hand, please print.
3. The issue of this form is not an admission of liability.

Instructions

1. Please **fully** complete Sections 1 - 5 of the claim form including the injury statement. We cannot proceed with the claim without this information.
2. Your Organisation completes the Organisation Declaration (Section 6).
3. Ensure you sign the Medical Authority and Declaration (Section 7).
4. For the Self Employed, please provide your tax assessment advice from the ATO for the previous financial year as proof of your income.
5. For Employees, please have your Employer fully complete Section 8 of the claim form and include 12 months payroll history prior to the date of disablement.
6. Your Doctor completes the Medical Practitioner's Statement (Section 9).
7. Attach a copy of supporting documentation for any Medical Expenses to be claimed.
8. Scan and email the claim form through to **liberty@csnet.com.au**

Liberty Specialty Markets
c/- Corporate Services Network
GPO Box 4276, Sydney NSW 2001

T: +61 2 8256 1770
F: +61 2 8256 1775
E: liberty@csnet.com.au

1. POLICY AND PERSONAL INFORMATION – ALL QUESTIONS REQUIRE COMPLETION

Policy no

Title | Given name(s) | Male ☐ Female ☐

Family name | Date of birth

Residential address

Suburb | State | Postcode

Daytime contact number | Alternative number

Email (important)

2. EFT AUTHORISATION

I hereby authorise and request that Corporate Services Network credit my bank account as indicated below

Account holder's name

BSB no | Account no | Bank

3. DETAILS OF ACCIDENT & INJURY

Date of accident | Time | AM ☐ PM ☐

Address where accident occurred

Were there any witnesses to the accident? Yes ☐ No ☐

Witness name(s)

Witness address

Please describe how the accident/injury occurred

What were the injuries?

Have you previously been treated for the same or a similar injury? Yes ☐ No ☐

If Yes, please give details

Give details of any previous claim made for any previous injury against any insurance company
(Please attach separate sheet if insufficient space)

During the 24 hours before the injury, did you drink any alcohol or take any drug(s) and/or prescribed medication? Yes ☐ No ☐

If Yes, please state types & quantities

4. TREATMENT RECEIVED

Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

When did you first obtain treatment? Time AM ☐ PM ☐

Name of current treating doctor

Clinic name/address

Name of regular doctor

Clinic name/address

Date first consulted doctor Date last consulted doctor

How long have they been your regular doctor? Years Months

Was hospital treatment required? Yes ☐ No ☐

If Yes, please complete the following regarding your hospital stay (please attach separate sheet if insufficient space)

From	To	Hospital name	Hospital address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors name	Address	Telephone number

5. NON-MEDICARE MEDICAL EXPENSES

IMPORTANT: PLEASE DO NOT ATTACH ACCOUNTS PAID OR PART PAID BY MEDICARE
The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap or the Medicare out of pocket amount)

Are you a member of an Ambulance Service? Yes ☐ No ☐

If Yes, please give details

Are you a member of a Private Health Fund? Yes ☐ No ☐

If Yes, please give details

Does your Private Health Insurance have hospital cover? Yes ☐ No ☐

Does your Private Health Insurance cover extras (Physio etc.)? Yes ☐ No ☐

Name of provider	Service (e.g. physio)	Date of service	Charged amount	Private Health Rebate	Amount claimable
				Total (AUD)	
				Less excess (AUD)	
				Total amount of claim (AUD)	

6. ORGANISATION DECLARATION

Organisation Name		
Organisation Official's Name		
Organisation Official's Position		
Address		
Suburb	State	Postcode
Daytime contact number	Email (important)	

I, the above mentioned Organisation Official, confirm that

(MEMBER'S NAME) _____ was a

Voluntary Worker for the Organisation and was an insured person as identified in the Personal Accident Insurance with Liberty Specialty Markets at the time of the accident. The information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Are there any comments in relation to this claim? Yes ☐ No ☐

If Yes, please give details

Signature of official	Date

7. MEDICAL AUTHORITY AND DECLARATION

I understand that by investigating my claim or by accepting proof of my claim, neither Corporate Services Network (CSN) or Liberty Specialty Markets (Liberty) have made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN or Liberty using and disclosing my personal information pursuant to their 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 CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN or Liberty such personal information (including health information) as CSN or Liberty in their 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 cooperation to CSN or Liberty 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 if I do not consent to the terms of this authority or revoke my consent, CSN or Liberty may not be able to process or assess my claim.

I appoint CSN or Liberty 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 of claimant | Date

Name of claimant

Signature of witness (any adult person) | Date

Name of witness

Privacy Notice

Liberty Specialty Markets (Liberty) and Corporate Services Network (CSN) are bound by the Privacy Act 1988 (Cth) and its associated Privacy Principles when collecting and handling your personal information. For the purposes of this Privacy Notice, 'we', 'us' or 'our' refers to, if the context permits, both Liberty and CSN.

Liberty collects personal information in order to provide insurance services and products and for ancillary business purposes and CSN collects personal information in order to provide claim assessments and insurance related services. Liberty and CSN may pass personal information to third parties involved in this process such as its related companies, reinsurers, agents, loss adjusters and other service providers. We may also store your information with third party cloud or other types of networked or electronic storage providers. Third parties may be located locally or overseas in the United States, Canada, UK, Singapore, Hong Kong and Malaysia.

Your information may be transferred to countries without comparable privacy laws if it is reasonably necessary to provide you with the products or services you seek from Liberty and CSN. If you do not provide the personal information Liberty, CSN or other relevant third parties require to offer you specific products or services, Liberty or CSN may not be able to provide the appropriate type or level of service.

If you wish to gain access to or correct your personal information, make a privacy complaint, or if you have any query about how Liberty or CSN collects or handles your personal information please write to Liberty's Privacy Officer at **privacy.officer.ap@libertyglobalgroup.com** or call +61 2 8298 5800 and/or CSN's Privacy Officer at **privacy@csnet.com.au** or call +612 8256 1770.

To obtain a copy of Liberty's Privacy Policy go to Liberty's website (libertyspecialtymarkets.com.au) or request a copy from Liberty's Privacy Officer. To obtain a copy of CSN's Privacy Policy go to CSN's website (csnet.com.au) or request a copy from CSN's Privacy Officer.

When you give Liberty or CSN personal or sensitive information about other individuals, Liberty and CSN rely on you to provide its Privacy Notice to them. If you have not done this, you must tell us before you provide the relevant data.

8. TO BE COMPLETED BY YOUR EMPLOYER

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

Employer's name

This is to certify that _____

has been unable to attend their occupation as a result of Injury

From Until

Their average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was AUD$

Has your employee's last 12 months payroll history been attached with this report, and if not please provide Yes ☐ No ☐

Their sick leave entitlement as at the date of injury or illness Days

They have been employed since

Please confirm if they are still an employee Yes ☐ No ☐

Please confirm date they were no longer employed

Has a claim for Workers' Compensation been lodged Yes ☐ No ☐

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission/CTP Insurer? Yes ☐ No ☐

Signature of supervisor or manager

Name of supervisor or manager (Please print)

Telephone number Date

9. MEDICAL PRACTITIONER'S STATEMENT

The claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly

Patients name	Date of birth
Height	Weight

Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound)

Cause

Is this condition An injury ☐ An illness ☐

Does the patient have any other injury or illness that is contributing to the condition? Yes ☐ No ☐

Provide details

Date of onset/first symptoms?

When did the patient first consult you for this condition?

Has the patient ever had the same or similar condition? Yes ☐ No ☐

From when & diagnosis

Name of patient's usual doctor/medical practice

How long have you been the patient's usual doctor/medical practice?

If the patient was hospitalised please provide Admission date Discharge date

Name of hospital

Please outline all treatment received to date AND required in the management of your patient's condition. Please include any relevant medical documents, reports or investigative scans.

Is the patient disabled?

No ☐ when did the patient return to work?

Yes ☐ how long will the patient be

– totally disabled (unable to perform any part of their occupation) from to

– partially disabled (able to perform part of their occupation) from to

Signature of medical practitioner

Name and qualifications (print)

Address

Telephone

Date