CORPORATE SERVICES NETWORK

Arch | Insurance

Income Protection Claim Form

EMAIL: CLAIMS@CSNET.COM.AU
PHONE: +61 2 8256 1770
FAX: +61 2 8256 1775
GPO BOX 4276
SYDNEY NSW 2001

INSTRUCTIONS:

1. You fully complete Sections 1 - 5 of the claim form including either the illness or injury statement. We cannot proceed with the claim without this information
2. Ensure you sign the privacy declaration (Section 7)
3. **YOUR EMPLOYER** fully completes Section 8 of the claim form.
4. **YOUR DOCTOR** fully completes the two page "Medical Practitioners Statement"
5. Attach a copy of your most recent Payslip to your claim submission.
6. Scan and email the claim form through to claims@csnet.com.au

We cannot proceed with the claim without this information.

FAQ's:

How long will it take to complete my section of the form?

This should only take about 10 - 15 mins. We want to settle your claim for you as quickly as we can. If insufficient information is provided or if corrections are required this will likely lead to unwanted delays.

How can I check the progress of my claim?

Please contact Corporate Services Network (CSN) on (02) 8256 1770 and advise that your query relates to an Income Protection Claim.

Please provide the claim number you received from the acknowledgement notification.

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CLAIM FORM

PERSONAL ACCIDENT &/OR SICKNESS

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

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. **Note:** 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.

SECTION 1: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

Employer name

Policy Number

Title

Given Name(s)

Gender ☐ M ☐ F

Family Name

Date of Birth

Residential Address

Suburb

State

Postcode

Email Address (important)

Do you consent to us communicating with you by email? Y ☐ N ☐

Daytime Contact Number

Alternative Number

Occupation, Trade or Profession

Work Site / Location

For what are you claiming? ☐ Weekly Benefit ☐ Capital Benefit ☐ Non - Medicare Medical Expenses (If applicable)

SECTION 2: EFT AUTHORISATION

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

Account Holders Name

BSB Number (6-Digits)

Account Number

Bank

SECTION 3: DETAILS OF INJURY - COMPLETE IF AS A RESULT OF ACCIDENT

Date of Accident ☐☐ ☐☐ ☐☐☐☐ Time ☐☐ ☐☐ AM / PM ☐☐

Address where accident occurred:

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

Witness Name:

Witness Address:

Please describe how the accident / injury occurred:

What were the injuries?

Have you previously been treated from a similar or same 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)

During the 24 hours before the injury, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

If Yes, please state types & quantities:

SECTION 4: TO BE COMPLETED IF DISABILITY IS AS A RESULT OF AN ILLNESS / SICKNESS

The nature of illness

When did the Illness begin? ☐☐ ☐☐ ☐☐☐☐

Have you had this complaint before? ☐ Yes ☐ No If Yes, when:

and how long were you disabled?

SECTION 5: TREATMENT RECEIVED (1 of 2)

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 stop work? Time AM / PM

When did you first obtain treatment? Time AM / PM

Name of Current Treating Doctor

Clinic Name/ Address

Name of Regular Doctor

Clinic Name/ Address

First consulted Doctor:

Last consulted Doctor:

How long have you known this Doctor? YEARS MONTHS

If you have not seen the above Doctor for more than 5 years or have visited other than this Doctor, please provide the Doctors information for the past 5 years (If this is not completed, it may delay your claim):

Name of Doctor (1)

Clinic Name/ Address

First consulted Doctor:

Last consulted Doctor:

How long have you known this Doctor? YEARS MONTHS

Name of Doctor (2)

Clinic Name/ Address

First consulted Doctor:

Last consulted Doctor:

How long have you known this 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

SECTION 5: TREATMENT RECEIVED (2 of 2)

Is there any condition (past or present) affecting your current disability? ☐ Yes ☐ No

If Yes, please give details

Are you now:

Recovered	☐ Yes ☐ No	When did you return to work?	☐☐ ☐☐ ☐☐ ☐☐
Partially Disabled	☐ Yes ☐ No	When did you return to work undertaking part of?	☐☐ ☐☐ ☐☐ ☐☐
Totally Disabled	☐ Yes ☐ No	When do you expect to return to work?	☐☐ ☐☐ ☐☐ ☐☐

Have you made, or will you make, or are you entitled to make , a claim for benefits under any Workers' Compensation Act or Transportation Act because of this injury? ☐ Yes ☐ No

If Yes, please give details

	Claim Number (if known)	Name	Address
Employer			
Workers Comp / Transport Insurer			

Name of your Superfund

Superfund Membership No.

Are you entitled to Income Protection Benefits through your Superfund? ☐ Yes ☐ No

If yes, have you made a claim? ☐ Yes ☐ No Claim Reference Number:

Are you entitled to claim benefits for this Injury / Illness from other Insurers (i.e. Personal Income Protection Insurance), Persons, Company, Health Fund, Friendly Society or Government? ☐ Yes ☐ No

If Yes, please give details

Name	Address

Corporate Services Network (CSN)

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.csnet.com.au and send to privacy@csnet.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

Medical Authority and Declaration

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

I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN'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 CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN 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 cooperation to CSN 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 may not be able to process or assess my claim.

I appoint CSN 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: _____

SECTION 8: TO BE COMPLETED BY YOUR EMPLOYER

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

Employers Name:

This is to Certify that: has been unable to attend his/her occupation as a result of Injury or Sickness

From: Until:

His/Her 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 $:

PLEASE ATTACH THE EMPLOYEE'S PAY HISTORY FOR THE 12 MONTHS PRIOR TO THEIR LAST DAY AT WORK

Employee's Occupation:

Type of Employment: Permanent Full Time ☐ Permanent Part Time ☐ Casual ☐ Fixed Term/Contract ☐

Are they still employed: ☐ Yes ☐ No If no, please provide the last date they were employed:

His / Her sick leave entitlement as at the date of injury or illness. Days:

He/She has been employed since: Date:

Has a claim for Worker's Compensation been lodged ☐ Yes ☐ No

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

SIGNATURE OF SUPERVISOR or MANAGER:

NAME OF SUPERVISOR or MANAGER: (PLEASE PRINT)

TELEPHONE NUMBER:

DATED:

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

Patients Name | DOB: ☐☐ ☐☐ ☐☐☐☐

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

Is condition due to injury or sickness arising out of the patient's employment? ☐ Yes ☐ No

Provide Details

Was the disability sports related? ☐ 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 similiar 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 been hospitalized please provide; Admission Date ☐☐ ☐☐☐☐ Discharge Date ☐☐ ☐☐☐☐

Name of Hospital

Has the patient had surgery or is it anticipated? Yes No

Provide Details

Date performed or anticipated: ☐☐ ☐☐ ☐☐☐☐

Give name of hospital:

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

Was the patient referred by you or to you? ☐ Yes ☐ No

Provide Details

Doctors details

Date of referral ☐☐ ☐☐ ☐☐☐☐

Is the patient still 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 ☐☐ ☐☐ ☐☐☐☐

Has the patient requested medical evidence for the current disability to be issued to any other insurance company, accident commission, Workers Compensation insurer, Social Security, sports body or any other insurance body? ☐ Yes ☐ No

Name of Company/Contact/Claim Number:

Signature of medical practitioner: Date: ☐☐ ☐☐ ☐☐☐☐

Name + Qualifications (print):

Address:

Telephone:

WHAT TO DO WHEN FORM IS COMPLETE

1 Please complete all sections of this form (state N/A if not applicable). Ensure that the claimant, Employers and Medical Practitioner have signed this form.

2 Send this form to:

Corporate Services Network
GPO BOX 4276, Sydney NSW 2001, or Fax 61 2 8256 1775 or
claims@csnet.com.au

DISPUTES

Corporate Services Network has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.

Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.

If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access to the applicable insurer's Internal Dispute Resolution Committee who can review Your complaint.

If You or an Insured Person are still dissatisfied, the complaint may be referred, at no cost to you, to the Australian Financial Complaints Authority under the terms of the General Insurance Code of Practice.