

1. Client Details

Claim number, Policy number, Due date, Insured's name, Address, Postcode, Insured persons name, Age, Occupation, Phone number

2. Goods and Services Tax (G.S.T.)

To ensure you do not incur any unnecessary GST liabilities on this claim please advise your:

(a) ABN, if applicable

ABN input field

(b) entitlement to an Input Tax Credit in respect of:

(i) Insurance premium % and (ii) the property which is the subject of this claim %

3. Accident Details

Particulars of accident:

Date, Time

Where did the accident happen?

Where did the accident happen? input field

State clearly how the accident occurred

State clearly how the accident occurred input field

Nature of injury sustained

Nature of injury sustained input field

Names and addresses of witnesses

Names and addresses of witnesses input field

Table with columns for State (NSW, VIC, ACT, TAS, SA, WA, QLD, NT), Address, Phone, and Fax numbers for Lumley House locations.

4. Illness Details

State nature of illness

Date first contracted (dd/mm/yyyy)

5. Medical Attention

Who first treated you for the illness or injury?

When (dd/mm/yyyy)

Is this person your usual medical attendant?

No Yes

If not, please advise name and address of your usual doctor

Have you received medical treatment during the last five years?

No Yes

If so, give details

Have you, as the direct result of the illness or accident, been totally incapacitated from attending to business of any kind?

No Yes

If so, state for how long

Are you still totally incapable of attending to business of any kind?

No Yes

If now able to attend any portion of your business or occupation, state when you commenced to do so. (dd/mm/yyyy)

Have you fully resumed your usual business or occupation?

No Yes

If so, when (dd/mm/yyyy)

I hereby warrant the truth of the foregoing statement.

6. Privacy Statement

This information will be treated with confidentiality and will only be released as per the requirements **the National Privacy Principles under the Privacy Act 1988 (Cth)**. We collect and store the information for the sole purpose of maintaining your insurance details. If you require any further information, please contact your local Lumley General state office. Signature

Date (dd/mm/yyyy)

The issue of this claim form is not an admission of liability on the part of the Company

Certificate of Medical Attendant

Name of claimant

So far as you are aware, how did the injury arise, or when did the sickness occur?

When did he/she first consult you in connection with this accident or illness? (dd/mm/yyyy)

Are you the usual medical attendant?

No Yes

If so how long have you known him/her?

Please state fully the nature of the injuries sustained, or illness
(If it is a limb or eye injured or affected state whether right or left?)

Are the symptoms from which he/she suffers due to the accident or illness alone?

No Yes

Have you any reason to suspect that the Claimant was under the influence of drink or drugs at the time of the accident?

No Yes

Is the Claimant suffering from any disease in addition to the present injuries or has he/she any physical defect?

No Yes

If so, state the nature of same, and to what extent the recovery may be affected thereby.

If the Claimant is in your opinion unable to give any attention to his/her profession or occupation, as described on the front page, or to perform any part of his/her usual duties, please state:

Date of commencement total disablement (dd/mm/yyyy)

Final date of total disablement (dd/mm/yyyy)

In the event of the Claimant being able to give partial attention of such profession or occupation or to perform some part of his/her usual duties,

Date of commencement partial disablement (dd/mm/yyyy)

Final date of partial disablement (dd/mm/yyyy)

Has the Claimant ever suffered from this or a similar complaint?

No Yes

If so, when?

Is the complaint of a chronic or recurring nature?

I CERTIFY that to the best of my belief the foregoing statements are correct.

Signature

Qualifications

Address

Date (dd/mm/yyyy)