

Have you returned to work full-time?				No:	Yes:	-when	/	/
Have you returned to work part-time? working?				No:	Yes:	- if Yes, what hours are you		
Duties:				Days	Hours			
Who is your usual family doctor?								
Name:								
Address:								
Telephone Number:								
When did you first get treatment from a medical practitioner for this condition?								
Doctors Name:								
Address:								
Telephone Number:								
When did you first see the medical practitioner?				/	/			
During the 24 hours before the injury, did you drink any alcohol or take any drugs?								
No:				Yes:				
State types and quantities:								
Are you affected by any long tem or chronic disability?				No:	Yes:	- give details -		
OTHER INSURANCE / BENEFITS								
Are you claiming insurance or compensation from any other insurance company? eg. Workers Compensation, Traffic Accident Commission, sports body or any income replacement.								
No:				Yes: - give details below:				
Name of organisation:								
Name of Insurer & Telephone Number:								
Type of cover:								
Amount Claimed:								

EMPLOYMENT DETAILS

What is your occupation?	
Please describe your duties:	
Name & Address of Employer:	
Please state average annual gross and net salary over previous 12 months from the date of the accident (please ensure you enclose a copy of your most recent payslip) or over the previous 36 months from the date of accident if self employed (please provide evidence of income by means of Australian Tax Office Tax Returns).	
Gross:	Net:

PAYEES BANK DETAILS

When the claim has been approved the payment will be credited direct to your Bank Account.
Please complete the following:

Name and address of your Bank:

Account Name(s): _____

Account Number: _____

BSB Number: _____

DECLARATION AND AUTHORISATION COMPLETE FOR ALL CLAIMS

I declare that the information on this form and any documents attached to it, is correct and complete and that I have not withheld any information that could effect this claim.

I authorise any hospital, physician or other person who has attended me to furnish the claims manager Proclaim Pty. Ltd or its representatives any and all information with respect to any sickness or injury, medical history, consultation, prescriptions, or treatment, copies of all hospital or medical reports. I agree that a Photocopy of this authorisation shall be considered as effective as the original.

Your Signature:

Name – print

Date:

**THIS SECTION MUST BE FULLY COMPLETED BY ATTENDING DOCTOR
 ANY FEE FOR COMPLETION OF THIS SECTION IS THE RESPONSIBILITY OF THE INSURED PERSON
 Section 3. – to be completed by Doctor**

Doctors STATEMENT

Patient's Name:
(Mr, Mrs, Miss, Ms)
Date of Birth:
Height:
Weight:
Please give full details of injury/illness:
Final diagnosis:
When did the patient first receive medical attention for this condition?
Has the patient ever suffered with this or any similar condition before the present episode? YES/NO
If YES, please give details including dates treatment and consultation:
Are you the patient's usual doctor? YES/NO
If NO, please give name and address of usual doctor:
On what date did incapacity commence?
Is patient still incapacitated? YES/NO
If YES when will patient be able to return to work?
If NO when did incapacity cease?
Was the patient hospitalised as a result of this condition? YES/NO
How many days was the patient hospitalised?
Is the condition due to injury or sickness arising out of the patient's employment? YES/NO
Signed:
Date:
Qualifications:
Please use validation stamp or complete in block capitals:-
Name:
Address:
Validation Stamp:
Telephone No:

Thank you for your assistance in completing this form.

Lodge your claim with Proclaim: e-mail address rwalker@proclaim.com.au
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