



# Personal Accident Supplementary Claim

**Policy Number**

**Claim Number**

**NOTE:** TOTAL DISABLEMENT is the total disablement of the Insured Person from carrying out all the normal duties of his or her usual occupation. PARTIAL DISABLEMENT is, in the case of accident, the partial disablement of the Insured Person from carrying out the normal duties of his or her occupation.

The Insured							
Name of Policy Holder	<input type="text"/>						
Name of Insured Person	<input type="text"/>						
Postal Address	<input type="text"/>					State	<input type="text"/>
			Postcode		<input type="text"/>		
Date of last medical attendance	/ /						
State how long you have been:	confined to house	from	/ /	to	/ /		
	able to get out	from	/ /	to	/ /		
State how long you have been:	totally disabled	from	/ /	to	/ /		
	partially disabled	from	/ /	to	/ /		
Signature of Policy Holder	<input type="text" value="X"/>				Date	<input type="text" value="/ /"/>	
Signature of Insured Person	<input type="text" value="X"/>				Date	<input type="text" value="/ /"/>	

Medical Certificate (to be completed by attending physician)							
1. Are you still attending the Insured Person?							Yes <input type="checkbox"/> No <input type="checkbox"/>
2. What are his/her present symptoms?							
<input type="text"/>							
<input type="text"/>							
3. State how long has he/she been:							
i) totally disabled	from	/ /	to	/ /			
ii) partially disabled	from	/ /	to	/ /			
4. If the Insured Person is still totally disabled, please state probable date of his/her being able to resume a portion of his/her usual duties.							<input type="text" value="/ /"/>
5. How much longer is it probable the Insured Person's state of disability will continue?					days/weeks/years		
6. General remarks							
<input type="text"/>							
<input type="text"/>							
<input type="text"/>							
<input type="text"/>							
<input type="text"/>							

## Declaration and Authorisation

The information and answers given above are true, correct and complete in every detail.

1. I/We understand the claim may be refused if information is not true or is withheld.
2. I/We authorise QBE Insurance (Australia) Limited to give to and obtain from other insurers, insurance reference bureaus and credit reporting agencies any information relating to the Insured's credit or insurance history as well as insurance claims information obtained during the course of this contract.

**Medical Authority:** I authorise any hospital, physician or other person who attended me, to give QBE Insurance (Australia) Limited or its representative any or all information with respect to any illness or injury, medical history, consultation, prescription, or treatment, and copies of all hospital or medical records. I also agree that copies of all employer records including verification of earnings can be provided.

A photocopy of this authorisation will be considered as effective and valid as the original.

Signature of Insured 1.

Date

Signature of Insured 2.

Date

**PLEASE CHECK THAT THIS FORM HAS BEEN FULLY COMPLETED AS ANY OMISSIONS MAY DELAY YOUR CLAIM.**

**Return the completed form to your Financial Services Provider or mail to QBE Insurance, GPO Box 4229, Sydney NSW 2001.**