

ILLNESS CLAIM FORM

This form is to be completed when a worker has suffered an illness, outside working hours and wishes to claim Weekly Benefits. This form should be completed as soon as it appears that you will be off work due to an illness.

The form has three parts which need to be fully completed.

Section A WORKERS STATEMENT

The worker needs to complete ALL questions in this section of the form, being the first 3 pages. Incomplete answers and vague information will delay the assessment of your claim.

Section B ATTENDING PHYSICIANS STATEMENT

The workers treating doctor must complete the Attending Physicians Statement following completion by the Worker of the Workers statement (section A). Any charge for completion of this statement must be borne by the worker.

Section C EMPLOYER STATEMENT

The workers employer must complete Section C of this form.

IMPORTANT

A claim, cannot be assessed until we receive the ORIGINAL claim form, completed in FULL, by the Worker, Attending Physician and Employer. The issue of this form does not constitute an admission to liability on the part of us.

Please forward the claim form to:

TOTAL CLAIMS SOLUTIONS PTY LTD
A.B.N. 42 389 515 023
(Acting as Claims Managers on behalf of QBE Insurance (Australia) Limited A.B.N. 78 003 191 035)
Level 6, 101 Wickham Terrace, Brisbane, QLD 4000
PHONE: (07) 3839 8322 FAX: (07) 3839 8500

SECTION A WORKER DETAILS

Union Membership number		Are you (please tick)	BLF <input type="checkbox"/>	CFMEU <input type="checkbox"/>	CEPU <input type="checkbox"/>	NO UNION <input type="checkbox"/>	BUSSQ Number	
Worker	Surname				Given name(s)			
Address (No PO Box)								
			State		Postcode			
Telephone number	Private ()				Business ()	Mobile		
Date of birth			Height		Cm	Weight	Kg	
Occupation					Sex	<input type="checkbox"/> Male	<input type="checkbox"/> Female	
Marital status	<input type="checkbox"/> Single <input type="checkbox"/> Married <input type="checkbox"/> Defacto							

EMPLOYMENT DETAILS (attach copy of last or most recent payslip)

Name of company								
Payroll officer								
Company address								
			State		Postcode			
Phone number	()				Fax Number			
What date did you commence employment with this company?								
Are you still employed?	<input type="checkbox"/> NO <input type="checkbox"/> YES							
If no when did you cease employment?								

PLEASE ATTACH A COPY OF YOUR LAST PAY SLIP

THIS INFORMATION WILL BE VERIFIED WITH YOUR EMPLOYER

ILLNESS DETAILS

Give the exact date your illness commenced.																					
When did you cease work as a result of this illness?																			am/pm		
Have you returned to work? If so, please provide date.																					
If you have not returned to work, please advise the date you expect to return to work.																					
State in full detail, the illness/es you are suffering from.																					
Did your illness result due to your employment?										<input type="checkbox"/> NO <input type="checkbox"/> YES		If your illness is work related, have you lodged a claim with WorkCover? If so, please advise the name of your WorkCover insurer and claim number.									
Insurer										Claim Number											
Have you had a similar condition before?										<input type="checkbox"/> NO <input type="checkbox"/> YES		If yes, give details of the physician/hospital or specialist attended.									
Doctor's Name					Address					Telephone					Date attended						
										()											

YOUR PHYSICIAN'S DETAILS

Give the details of first physician/hospital or specialist attending to you for this illness.																			
Doctor's name					Address					Telephone					Date attended				
										()									
Details of all other attending physicians and dates attended																			
Doctor's name					Address					Telephone					Date attended				
										()									
										()									
Who is your usual family doctor?																			
Doctor's name					Address					Telephone									
How long have you been receiving treatment or advice from this doctor?										Years					Months				

TREATMENT DETAILS

Are you receiving treatment for your illness? If yes, please give details of the treatment you are presently receiving. Please complete the following table.														
Type of treatment														
Date commenced					Date of next treatment					Date treatment ceased				
Name and contact number of provider					Name					Telephone				
										()				

MEDICAL & CLAIMS HISTORY

What other medical or surgical treatment have you received during the past 5 years?

Date	Nature of treatment	Doctor's Name	Address

Are you now, or have you ever been, subject to or affected by any other injury, disease, deformity, defect of senses, infirmity or weakness? No Yes (give details)

Have you ever lodged a personal illness claim before? No Yes (give details)

Are you making or entitled to make any other insurance or compensation claim in respect of this disability?

Sick Leave NO YES Motor Compensation NO YES WorkCover NO YES

Private Health Fund NO YES Other Government Benefits NO YES Superannuation Life Insurance NO YES

Other _____ Name of fund/insurance company _____

Case Manager _____ Claim Number _____ Telephone _____ ()

PRIVACY

QBE includes information about how we manage your personal information in our Product Disclosure Statements and Policy booklets. You can obtain a copy of the **QBE Privacy Policy Statement** from our website www.qbe.com or contact the Compliance Manager on (02) 9375 4656 or email compliance.manager@qbe.com for further information.

PAYMENT DETAILS

If your claim is accepted, please advise what method you would like to receive payment.

Cheque Electronic Fund Transfer

To enable your benefits to be paid directly into your bank account you need to fill in your bank details below. This will give you direct access to the funds instead of waiting for a cheque to be cleared.

PLEASE NOTE: We depend on the accuracy of the details you are providing to us. Please write clearly and check with your bank if you are unsure of the bank details.

Name of Bank	Bank Phone Number
BSB Number (6 digits)	Type of Bank Account i.e. Savings
Bank Account Number	Name in which Account is held

I, _____ (name in full)

Hereby authorise QBE Insurance (Australia) Limited and or Total Claims Solutions Pty Ltd to pay my benefits directly into my bank account.

Signature	Date
Print Name	

DECLARATION & AUTHORISATION BY PERSON CLAIMING

1. I authorise any hospital, physician or other person who has attended me, or any employer, 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 relevant to my claim including verification of earnings can be provided
2. I give permission for QBE Insurance (Australia) Limited or its representative to obtain a copy of any police report with respect to my claim.
3. A photocopy of this authorisation will be considered as effective and valid as the original
4. I understand that Total Claims Solutions Pty. Ltd act as claims managers on behalf of QBE Insurance (Australia) Limited
5. I also authorise that QBE Insurance (Australia) Limited, or its representatives, to give to and obtain from other insurers and/or statutory authorities, or their representatives, 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.
6. I also agree for the administrators of my BUSSQ, BERT and CIPQ to supply details of all employer payments and any other payments or entitlements I may receive.
7. I declare that the preceding statements and information are, to the best of my knowledge and belief, true in every aspect.
8. I understand the claim may be refused if information is not true or is withheld.

The signatory must be authorised to sign on behalf of all named persons.

Signature	Date
Print Name	

SECTION B ATTENDING PHYSICIAN'S STATEMENT

THE PATIENT WILL BE RESPONSIBLE FOR ANY FEE CHARGED TO COMPLETE THIS STATEMENT

TO BE COMPLETED BY YOUR TREATING DOCTOR/SURGEON

Patient's Name	Age	Occupation

Patient's Address

Please state in full detail the primary illness causing the patient's disablement.

PLEASE ENCLOSE COPIES OF ALL TESTS RESULTS, IF ANY, WHICH HAVE DETERMINED THE ABOVE LISTED DIAGNOSIS.

Please list all other illness/es, if any, affecting the patient's disablement?

When did the patient first consult you for this illness? _____/_____/_____

When did the patient last consult you for this illness? _____/_____/_____

What is the cause of the patient's illness?

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Has the patient's work activities caused or significantly contributed, aggravated, accelerated, or exacerbated or deteriorated a pre-existing condition causing the patient's current disablement? Please give details.

Give details of any circumstances such as the use of alcohol and or drugs, which has caused and or significantly contributed to the patient's illness.

How long have you known this person in a professional capacity? Years Months

Has the patient ever had the same or similar condition? If "Yes" state when and describe whether this has an impact on current disablement.

Please supply the first initial date followed by the periods, you have given advice to the patient for this or any related illness. Please include the nature of consultation/s.

Has the patient been hospitalised? NO YES If yes, Name of Hospital _____

Date of Admission _____/_____/_____ to _____/_____/_____

SECTION B ATTENDING PHYSICIAN'S STATEMENT - CONTINUED

What date was the treatment prescribed?							
Please advise what prescribed medication and treatment was given to the patient for this or any related illness including the duration of such treatment/medication.							
Has treatment been terminated? If so, please give date ceased.							
Frequency of Visits	<input type="checkbox"/> Weekly <input type="checkbox"/> Monthly <input type="checkbox"/> Other _____						
Is the patient following your prescribed treatment?	<input type="checkbox"/> NO <input type="checkbox"/> YES		If, No, please give details				
When will the patient be fit to return to his/her normal occupation or alternative duties? Please state which.							
Are there any complications regarding recovery?							
What is your prognosis?							
Have you told the patient to restrict employment activities? If so, please advise the date the restrictions began and the date the restrictions ended.							
Date Commenced						Date Ended	
Explain the specific restrictions and limitations.							
Do you expect a fundamental or marked change in the patient's illness? If yes, when will the patient recover sufficiently to return to work?							
<input type="checkbox"/> 1 month <input type="checkbox"/> 1-3 months <input type="checkbox"/> 4-6 months Other _____							
Can present job be modified to allow the patient to work with their disability? If yes, please advise the date the trial will commence and indicate whether full-time or part-time. If part-time how many hours per day and per week.							
Would vocational counselling and/or retraining be recommended? If yes, please specify.							
With regard to the patient's occupation, how long was or will patient be continuously totally disabled? (Unable to perform any part of his/her occupation)							
TOTALLY DISABLED FROM:						TO:	
(BOTH DATES INCLUSIVE)							
How long was or will patient be partially disabled? (Unable to perform some part of his/her occupation)							
PARTIALLY DISABLED FROM:						TO:	
(BOTH DATES INCLUSIVE)							
Name (Please Print)						Date	
Address (Please Print)							
Telephone	()		Fax Number	()			
E-mail							
Medical Qualifications							
Signed							

SECTION C - THIS SECTION TO BE COMPLETED BY YOUR EMPLOYER

Business/Trading Name		CIPL Employer Number	
Address			
State		Postcode	
Telephone ()	Fax Number ()		
E-mail			
Name of Employee			

What is the Employee's Job Classification? (occupation).		
Please state the Employees current Gross weekly earnings excluding overtime & allowances at the date of illness. (The base rate of pay)		\$
The employee's hourly rate of pay at the time of the illness		\$
Reason employee stopped working?	<input type="checkbox"/> Illness <input type="checkbox"/> Injury <input type="checkbox"/> Other (please specify) _____	
Is the employee entitled to Workers' Compensation benefits?	<input type="checkbox"/> NO <input type="checkbox"/> YES	If so, please confirm the details of this claim also including a copy of his/her WorkCover Claim form.
Insurer	Claim Number	

ATTACH A COPY OF THE JOB DESCRIPTION CARRIED OUT BY THE EMPLOYEE.

If employee was partially disabled (fit for light duties), would any sedentary (light/manual work or administration) work be available? If so, please give details.

RTW Coordinator's Name		Telephone
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Was the worker employed at the time of suffering the illness?	<input type="checkbox"/> NO <input type="checkbox"/> YES	If Yes, supply address and worksite where worker was stationed prior to illness?
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Job Site	Address
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What date did the employee commence working for you?									
The date the employee last worked for you, prior to the illness?									

Has the employee returned to work?	<input type="checkbox"/> NO <input type="checkbox"/> YES	If yes, what date? ____/____/____
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Has the employee received any sick leave payments in respect to the illness being claimed?	<input type="checkbox"/> NO <input type="checkbox"/> YES	Number of days ____
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The last date the employee was paid sick leave.									
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How many sick leave days does the employee have owing?	Number of days entitled _____
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I hereby declare that the information I have provided on this form is to the best of my knowledge and belief, true in every respect.

Officer's Name (Print)	Position
Telephone Number ()	E-mail
Signature	Date ____/____/____

PLEASE ATTACH COPIES OF ALL MEDICAL CERTIFICATES THE EMPLOYEE HAS SUPPLIED YOU FOR THIS ILLNESS.