

SELF EMPLOYED ILLNESS CLAIM FORM

This form is to be completed when a self employed worker has suffered an illness 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 two parts which need to be fully completed.

Section A INSURANCE STATEMENT

The insured 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 insured's treating doctor must complete the Attending Physicians Statement following completion by the Insured of the Insured's statement (section A). Any charge for completion of this statement must be borne by the Insured.

IMPORTANT

A claim, cannot be assessed until we receive the ORIGINAL claim form, completed in FULL, by the Insured, and Attending Physician. 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 INSURED DETAILS

| | | | | | | | | |
|-----------------------|---------------------------------|----------------------------------|----------------------------------|----------|-------------------------------|---------------------------------|--------|----|
| Insured Person | Surname | | | | Name(s) | | | |
| Business Trading Name | | | | ABN | | | | |
| Address (No PO BOX) | | | | State | | Postcode | | |
| Telephone number | Private | () | | Business | () | Mobile | | |
| Date of birth | | | | Height | | Cm | Weight | Kg |
| Marital status | <input type="checkbox"/> Single | <input type="checkbox"/> Married | <input type="checkbox"/> Defacto | Sex | <input type="checkbox"/> Male | <input type="checkbox"/> Female | | |

EMPLOYMENT DETAILS

1. What is your job specification and usual duties?

2. Please state your current Gross weekly earnings. **Please attach a copy of your most recent tax return**

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

4. Were you working before your illness? If so, please provide us with the site name and address of where you were working.

Please attach a copy of your most recent tax return including details of your Profit and Loss Expenditure

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

| | | | | | |
|---------------------|--|---------------------------|--|-------------------------------|--|
| Sick Leave | <input type="checkbox"/> NO <input type="checkbox"/> YES | Motor Compensation | <input type="checkbox"/> NO <input type="checkbox"/> YES | WorkCover | <input type="checkbox"/> NO <input type="checkbox"/> YES |
| Private Health Fund | <input type="checkbox"/> NO <input type="checkbox"/> YES | Other Government Benefits | <input type="checkbox"/> NO <input type="checkbox"/> YES | Superannuation Life Insurance | <input type="checkbox"/> NO <input type="checkbox"/> 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.

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|--|--|--|--|--|--|--|-----------------------------------|--|--|--|--|-------------------------------|--|--|--|--|--|--|
| 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

- 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
 - I give permission for QBE Insurance (Australia) Limited or its representative to obtain a copy of any police report with respect to my claim.
 - A photocopy of this authorisation will be considered as effective and valid as the original
 - I understand that Total Claims Solutions Pty. Ltd act as claims managers on behalf of QBE Insurance (Australia) Limited
 - 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.
 - 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.
 - I declare that the preceding statements and information are, to the best of my knowledge and belief, true in every aspect.
 - 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.

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|------------|--|--|--|--|--|--|--|--|--|--|--|------|--|--|--|--|--|--|
| 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.

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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?

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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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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.

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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.

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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.

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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 Weekly Monthly Other _____

Is the patient following your prescribed treatment? NO 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?

1 month 1-3 months 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 can 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