CORPORATE SERVICES NETWORK

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VOLUNTARY WORKER CLAIM FORM

IMPORTANT: PLEASE READ BEFORE YOU COMPLETE THIS FORM

1. This form consists of several sections. Please provide answers to all of the information required in order to avoid delays with your claim.
2. **Note:** This form can be completed electronically. If completing this form by hand: Please print.
3. The issue of this form is not an admission of liability.

SECTION 1: POLICY AND PERSONAL INFORMATION - ALL QUESTIONS REQUIRE COMPLETION

Policy Number 330-01815481-14011

Title | Given Name(s) | Gender ☐ M ☐ F

Family Name | Date of Birth

Residential Address | Suburb | State | Postcode

Daytime Contact Number | Alternative Number | Email Address (important)

SECTION 2: EFT AUTHORISATION

I hereby authorise and request that Fullerton Health Corporate Services credit my bank account as indicated below:

Account Holders Name

BSB Number (6-Digits) | Account Number | Bank

SECTION 3: DETAILS OF INJURY (1 of 2)

Date of Accident | Time | AM / PM | Address where accident occurred:

Were there any witnesses to the accident? ☐ Yes ☐ No | Witness Name:

Witness Address:

Please describe how the accident / injury occurred:

SECTION 3: DETAILS OF INJURY (2 of 2)

What were the injuries?

Have you previously been treated from a similar or same injury? ☐ Yes ☐ No

If Yes, please give details:

Give details of any previous claim made for any previous injury against any insurance company: (please attach separate sheet if insufficient)

During the 24 hours before the injury, did you drink any alcohol or take any drugs? ☐ Yes ☐ No

If Yes, please state types & quantities:

SECTION 5: TREATMENT RECEIVED

Please outline all treatment received to date in the management of your condition. Please include any relevant medical documents, reports or investigative scans.

When did you first obtain treatment? ☐☐☐☐☐☐☐☐ Time ☐☐☐☐ AM / PM ☐☐

Name of Current Treating Doctor

Clinic Name/ Address

Name of Regular Doctor

Clinic Name/ Address

First consulted Doctor: ☐☐☐☐☐☐☐☐ Last consulted Doctor: ☐☐☐☐☐☐☐☐

How long have you known this Doctor? ☐☐ YEARS ☐☐ MONTHS

Was hospital treatment required? ☐ Yes ☐ No

If Yes, please complete the following regarding your Hospital Stay (please attach separate sheet if insufficient space)

From	To	Hospital Name	Hospital Address

Give details of all attending physicians (please attach separate sheet if insufficient space)

Doctors Name	Address	Telephone Number

SECTION 5: NON-MEDICARE MEDICAL EXPENSES

IMPORTANT: PLEASE DO NOT ATTACH ACCOUNTS PAID OR PART PAID BY MEDICARE

The Australian Health Insurance Act does not permit us to contribute to any charges covered by Medicare (including the Medicare gap or the Medicare out of pocket amount)

Are you a member of an Ambulance Service? ☐ Yes ☐ No If Yes, please give details:

Are you a member of an Private Health Fund? ☐ Yes ☐ No If Yes, please give details:

Does your Private Health Insurance have hospital cover? Yes ☐ No ☐

Does your Private Health Insurance cover extras (Physio etc.)? Yes ☐ No ☐

Name of Provider	Nature of Service (E.g Physio; Dental etc)	Date of Service	Charged Amount (AUD)	Private Health Fund Rebate (If Applicable)	Amount Claimable (AUD)
				Total (AUD)	
				Less Excess (AUD)	
				TOTAL AMOUNT OF CLAIM (AUD)	

SECTION 6 - ORGANISATION DECLARATION

Organisation Name

Organisation Official's Name

Organisation Official's Position

Address

Suburb

State

Postcode

Daytime Contact Number

Email Address (important)

I, the above mentioned Organsation Official, confirm that (MEMBERS NAME) _____ was a Working Voluntarily for the Organisation and was an insured person as identified in the Personal Accident Insurance at the time of the accident. The information contained in this statement is true and correct, and to the best of my knowledge and belief the information referred to in this claim form is true and correct.

Is there any comments in relation to this claim? Yes ☐ No ☐

If Yes, please give details

Signature of Official:

Date: ☐☐/☐☐/☐☐

Corporate Services Network (CSN)

CSN is committed to complying with the Privacy Amendment (Enhancing Privacy Protection) Act 2012 which amends the Privacy Act 1988 and has resulted in the introduction of the 13 Australian Privacy Principles (APPs). CSN will ensure that all personal information held is treated in accordance with the Act and the APPs.

All personal information collected is used only for the assessment of a claim or the provision of an insurance related service. In order to affect this, your personal information may be disclosed to or requested from third parties such as an insurer, employer, broker, medical practitioner, Medicare or other parties as required by law.

Consequently, given the placement of this insurance it may be necessary to disclose your personal information to a third party in the UK. If so, we will take reasonable steps to ensure that the overseas recipient of your information will not breach the APPs.

CSN will take all reasonable steps to ensure that personal information held by CSN is secure from any misuse, interference, loss, unauthorised access, modification or disclosure.

CSN has a privacy enquiries and complaints handling procedure to deal with any enquiry or complaint you may have about how we have collected, used or managed your personal information. If you would like to make an enquiry or complaint, please complete the "Privacy Complaint or Query" form that is available on our website at www.csnet.com.au and send to privacy@csnet.com.au

Our complete Privacy Policy is located on the above website or can be obtained from us by contacting 612 8256 1770. Both the Privacy Policy and Statement were last updated on 12 March 2014.

Medical Authority and Declaration

I understand that by investigating my claim or by accepting proof of my claim, CSN has made no acceptance of liability, nor waived any of its rights in defence of any claim arising under the policy.

I agree to CSN using and disclosing my personal information to the insurer, the Policy Holder, my employer, the insurance broker, my medical practitioners, my health providers, Medicare, or other parties as required by law. I understand this is pursuant to CSN's Privacy Policy and this document.

In the event of any conflict between the documents, this document will be determinative. This consent remains valid unless I alter or revoke it by giving written notice to CSN's Privacy Officer.

I authorise any person or entity, including those referred to above, to provide to CSN such personal information (including health information) as CSN in its absolute discretion considers relevant for its assessment of my claim or my entitlement to benefits.

I will use my best endeavours and render all reasonable assistance and cooperation to CSN in the assessment of my claim.

I confirm that any information that I supply will be true and correct and that I will not withhold any information likely to affect the acceptance or handling of my claim.

I understand that if I do not consent to the terms of this authority or revoke my consent, CSN may not be able to process or assess my claim.

I appoint CSN to do everything necessary or expedient to give effect to the transactions contemplated by the consents and authorisations in this document and to execute, on my behalf, any documents or to do such acts required to give effect to this Privacy Consent and Medical Authority.

Signature of Claimant: _____ Date: ☐☐/☐☐/☐☐

Name of Claimant: _____

Signature of Witness (any adult person): _____ Date: ☐☐/☐☐/☐☐

Name of Witness: _____

SECTION 8: TO BE COMPLETED BY YOUR EMPLOYER

WE ARE UNABLE TO PROCESS BENEFIT PAYMENTS WITHOUT CONFIRMATION OF INCOME

Employers Name:

This is to Certify that: has been unable to attend his/her occupation as a result of Injury or Sickness

From: ☐☐ ☐☐ ☐☐☐☐ Until: ☐☐ ☐☐ ☐☐☐☐

His/Her average Gross Weekly Salary (as defined by the policy wording) averaged over the previous 12 months at the time of this accident/sickness was: AUD $:

Has your Employees last 12 months payroll history been attached with this report, and if not please provide ☐ Yes ☐ No

His / Her sick leave entitlement as at the date of injury or illness. Days:

He/She has been employed since Date: ☐☐ ☐☐ ☐☐☐☐

Please confirm if he/she are still an Employee ☐ Yes ☐ No

Please confirm date they were no longer employed Date: ☐☐ ☐☐ ☐☐☐☐

Has a claim for Worker's Compensation been lodged ☐ Yes ☐ No

In the case of a motor vehicle accident has a claim been lodged against the Traffic Accident Commission/CTP? ☐ Yes ☐ No

SIGNATURE OF SUPERVISOR or MANAGER:

NAME OF SUPERVISOR or MANAGER: (PLEASE PRINT)

TELEPHONE NUMBER:

DATED: ☐☐ ☐☐ ☐☐☐☐

DISPUTES

Corporate Services Network has developed an internal procedure for dispute resolution so that if at any time our products or services have not met your expectations You or an Insured Person can contact Us.

Our Complaints and Disputes Resolution procedures will refer the complaint to senior management for review and a response within 10 working days.

If this does not resolve the issue or You or an Insured Person are not satisfied with the way a complaint has been dealt with, we will provide You with access to the applicable insurer's Internal Dispute Resolution Committee who can review Your complaint.

If You or an Insured Person are still dissatisfied, the complaint may be referred, at no cost to you, to the Australian Financial Complaints Authority under the terms of the General Insurance Code of Practice.

MEDICAL PRACTITIONER'S STATEMENT

The claimant is responsible for any fee for this statement. This form should be **FULLY** completed and returned promptly

Patients Name _____ DOB: ☐☐ ☐☐ ☐☐☐☐

Height: _____ Weight: _____

Diagnosis (if fracture or dislocation, describe nature and location i.e. Simple, Compound)

Cause:

Is this condition ☐ an injury ☐ an illness

Does the patient have any other injury or illness that is contributing to the condition? ☐ Yes ☐ No

Provide Details

Date of onset/first symptoms? ☐☐ ☐☐ ☐☐☐☐

When did the patient first consult you for this condition? ☐☐ ☐☐ ☐☐☐☐

Has the patient ever had the same or similiar condition? ☐ Yes ☐ No

From when & diagnosis:

Name of patient's usual doctor/medical practice :

How long have you been the patient's usual doctor/medical practice?

If the patient been hospitalized please provide; Admission Date ☐☐ ☐☐ ☐☐☐☐ Discharge Date ☐☐ ☐☐ ☐☐☐☐

Name of Hospital

Please outline all treatment received to date AND required in the management of your patient's condition.
Please include any relevant medical documents, reports or investigative scans.

Is the patient disabled?

No ☐ - when did the patient return to work? ☐☐ ☐☐ ☐☐☐☐

Yes ☐ - how long will the patient be:

- totally disabled (unable to perform any part of their occupation)

from ☐☐ ☐☐ ☐☐☐☐ to ☐☐ ☐☐ ☐☐☐☐

- partially disabled (able to perform part of their occupation)

from ☐☐ ☐☐ ☐☐☐☐ to ☐☐ ☐☐ ☐☐☐☐

Signature of medical practitioner: Date: ☐☐ ☐☐ ☐☐☐☐

Name + Qualifications (print):

Address:

Telephone: