

QBE LIFEstyle Solutions™

ACCIDENT AND HEALTH INSURANCE

Personal Accident / Illness Claim

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A. NOTES

1. It is most important that all questions are answered. If not applicable, write "n/a".
2. The issue of this claim form is not an admission of liability by QBE.
3. If there is insufficient space or further comment on any area is considered necessary, please use additional pages.
4. Any amounts further marked as * are in the currency of the country in which the policy has been issued.
5. Markets
Please use the checklist below to indicate the operation in the QBE Pacific Islands region to which you will be submitting your claim.

Market	Business Name	Please tick
Fiji	QBE Insurance (Fiji) Limited	
Papua New Guinea	QBE Insurance (PNG) Limited	
Solomon Islands	QBE Insurance (International) Limited	
Vanuatu	QBE Insurance (Vanuatu) Limited	

Note: For any other markets please contact the local QBE office.

6. The content and use of this form or any agreement entered into pursuant to this form or any dealing in relation to or arising from this form are governed by:
 - a) the laws of the country at the QBE office which issues the policy/ies upon which this present claim is made; unless
 - b) the policy/ies refer to the laws of a different country applying, in which case, the laws of that country,
 and in relation to those matters, the parties submit to the jurisdiction of the courts of that country.

For those policies governed by the laws of the Republic of Vanuatu, the validity, interpretation and effect and the rights and obligations of the parties to such policies shall be governed exclusively by English Law as applicable within Vanuatu immediately before 30 July 1980 and shall be justiciable before the Supreme Court of Vanuatu.

B. INSURED DETAILS

1. Name of insured:
2. Address:
..... Postcode:
3. Private tel no: Business tel no:
Mobile tel no: Fax no:
Email:
4. Occupation:
5. Name of affected party: Age:
6. Address:
7. Telephone no: Mobile no:

8. Have you ever previously met with an accident? YES NO

If "YES", please give full details below

.....

9. Have you ever previously suffered from any illness? YES NO

If "YES", please give full details below

Date	Nature of accident/extent of injuries and/or illness	Duration of disablement

10. Have you ever previously claimed under a personal accident or illness policy? YES NO

If "YES", please give particulars including name(s) of Insurer(s)

.....

11. Are you insured against accident or illness with any other company? YES NO

If "YES", please give full details

.....

12. Have you received or are you entitled to receive benefits under any workers' compensation act in consequence of this accident? YES NO

If "YES", please give full details

.....

13. Have you engaged in or attended to your business in any way since this accident occurred? YES NO

If "YES", please give full details

.....

14. Are you able to engage in or attend to your business in any way? YES NO

a) *If "YES", to what extent?*

b) *If "NO", when do you anticipate that you will be able to engage in or attend to your business in any way?*

.....

15. a) Are you confined to your bed? YES NO

b) Are you totally disabled? YES NO

c) State name and address of your medical attendant:

.....

16. Date of last medical attendance: ____ / ____ / ____

C. THE ACCIDENT / ILLNESS

1. If accident:
 - a) Date of accident: ___/___/___ Time:.....am/pm
 - b) Place of accident:
 - c) State exactly how the accident occurred?
.....
.....
 - d) State nature of injuries:
 - e) State name(s) and address(es) of witness(es) to accident:
.....
.....

2. If illness:
 - a) Nature of illness:
 - b) How long?
 - c) Please state how long you have been:
 - i) Confined to house from: ___/___/___ to: ___/___/___
 - ii) Able to get out doors from: ___/___/___ to: ___/___/___
 - d) Please state how long you have been:
 - i) Totally disabled from: ___/___/___ to: ___/___/___
 - ii) Partially disabled from: ___/___/___ to: ___/___/___

D. DECLARATION

- I/We declare that:
1. The information and answers given above are correct to the best of my/our knowledge and belief.
 2. I/We understand the claim may be refused or reduced if information is withheld.
 3. I/We authorise QBE to disclose information contained herein to QBE's advisors, reinsurers and to other insurers. I/We authorise QBE to obtain from any other party information that is, in QBE's view relevant to this claim.

Signature of insured: Date: ___/___/___

E. MEDICAL CERTIFICATE

To be completed by attending physician

Are you still attending the insured person? YES NO

What are his/her present symptoms?

.....

a) Totally disabled from: ___/___/___ to: ___/___/___

b) Partially disabled from: ___/___/___ to: ___/___/___

If the insured person is still disabled, please state the probable date of his/her being able to resume a portion of his/her usual duties? Date: ___/___/___

How much longer is it probable the person's state of disability will continue?

days weeks years

General remarks:

.....

I CERTIFY that to the best of my knowledge the foregoing statements are correct:

Name:

Address:

.....

Doctor's signature:..... Date: ___/___/___

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PNG

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Solomon Islands

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For literature in use in the French Territories above,
please contact the local QBE office in each of these countries.



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www.qbe.com