Personal Accident and Sickness Report form

Important notice

Material facts

'You' (this includes every person or entity to be insured under this insurance) are under a duty to disclose all material facts that could influence QBE Insurance's decision to accept this insurance and, if so, on what terms. You need to disclose facts both known to you and those which you could have been reasonably expected to know about. If you are in any doubt as to whether or not a fact may be material, you should disclose it to ensure that any cover granted is not prejudiced.

Non-disclosure/misstatement

If you fail to comply with your duty of disclosure, QBE may be entitled to avoid the contract altogether, and therefore decline to pay any claim.

Jurisdiction

Except where the parties agree otherwise, the laws of New Zealand apply to this form and any dealings between the parties arising from this form. The New Zealand courts have exclusive jurisdiction in relation to any disputes that may arise.

How to complete this form

- This certificate is to be completed by the medical attendant of and at the expense of the insured person.
- You must answer all questions fully and, if you are completing this form by hand, please ensure you write clearly.
- If you are completing this form electronically, please open it using the latest version of Adobe Reader. Use your mouse/trackpad to take the cursor to the next editable field. Boxes can be ticked either by using your mouse/trackpad or by hitting 'enter'. Upon completion, please print out this form and sign the declaration.
- The signed form should then be posted, or emailed, to your broker.

A Member details

1. Employer/Group/Bank group
2. Policy number
3. Full name
4. Phone
5. Email address

B Patient details

1. Full name
2. Phone
3. Date of birth dd / mm / yyyy
4. Full residential address
5. Email address
6. Relationship to member
7. Occupation

C Settlement details

1. Payee name

2. For payments into New Zealand accounts, please provide bank, branch and account numbers:

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3. For payments into overseas accounts, please provide the following:

   Bank | Branch | Country

   Swift/sort code | Account number

4. To confirm transfer of funds, an auto email will be sent to your broker or direct — I agree ◯

   Broker email address

   Payee email address

D Accident details

1. When did the accident occur? dd / mm / yyyy

2. Describe the accident

3. Describe the injuries

E Illness details

1. When did the first symptoms appear? dd / mm / yyyy

2. What is the medical diagnosis of your condition?

3. When did you first see a doctor for this condition? dd / mm / yyyy

   Doctor's name and address

4. Dates hospitalised — Admitted dd / mm / yyyy — Discharged dd / mm / yyyy

   Name and address of hospital

5. **Name of family doctor** Phone

Address

6. **Have you ever had this, or a similar condition, in the past?** Yes ○ No ○

If Yes, please provide all doctor's names and addresses, and dates consulted/treated.
Attach additional sheet if insufficient space and tick to indicate enclosure. Enclosed ○

Date	Name	Address

Your hospital admission/discharge summary must be provided with these fully completed pages.

Important notice

Your policy may contain a condition that if you receive any weekly compensation from Accident Rehabilitation and Compensation Insurance Corporation, then the amount of any such weekly compensation shall be deducted from any weekly or monthly benefits payable under this policy for the same period.

In consideration of QBE commencing the payment of benefits under this policy before the final determination of any weekly compensation from Accident Rehabilitation and Compensation Insurance Corporation I agree to refund to QBE any amount overpaid by QBE as a result of the delay in determining the amount of such weekly compensation.

Insured's signature ..... Date dd / mm / yyyy

Address

Declaration

I/We declare that:

(a) The information and answers given above are correct to the best of my/our knowledge and belief. I/We have not withheld any information likely to affect QBE's consideration of the claim.

(b) I/We understand that QBE requires this information (which will be retained by QBE) to evaluate the claim. I/We understand that the Privacy Act 1993 entitles me/us to have access to, and request the correction of, this information.

(c) QBE is authorised to disclose information received from me/us to its advisers, 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.

Signed by applicant ..... Date dd / mm / yyyy

Printed name Phone

Position Mobile

Email address

Please also have the physician's statement overpage completed and attached.

Attending physician's statement

This form must be completed without expense to the Insurer.

Please print clearly. If there is insufficient space for any answers please attach a separate sheet.

Patient's name

Age

A Medical condition

1. Diagnosis

Any complications? Yes No

If Yes, please give details.

2. What are the factors causing disablement?

3. When did patient first receive medical attention for the above? dd / mm / yyyy

By whom? Qualifications

4. Date discharged from your care dd / mm / yyyy

OR Proposed ongoing treatment

B Injury

1. If an injury, when did the accident occur? dd / mm / yyyy

2. Has injury described above resulted in any residual disability? Yes No

If Yes, please give full details and provide copies of specialist or other reports.

C Hospitalisation

1. Hospital admission date dd / mm / yyyy

2. Hospital name and address

3. What operation, if any, was performed?

4. **Were any other doctors/consultants attending?** Yes ○ No ○

If Yes, please provide details. Attach additional sheet if insufficient space and tick to indicate enclosure. Enclosed ○

Name	Specialty	Address/Email	Phone

D Prognosis/Extent of disability

1. **Patient's occupation**

2. **Has the patient been able to do any work?** Yes ○ No ○

If Yes, please provide capacity/start date Full duties dd / mm / yyyy Restricted duties dd / mm / yyyy

If No, please provide estimated capacity/start date Full duties dd / mm / yyyy Restricted duties dd / mm / yyyy

E Prior history

1. **Are you the usual family doctor for this patient?** Yes ○ No ○ Since what date? dd / mm / yyyy

2. **Has the patient ever previously had the same or a similar condition?** Yes ○ No ○

Date dd / mm / yyyy Condition

3. **Were you the treating physician?** Yes ○ No ○

If No, please provide details of the treating physician.

Name Phone

Address Email

F Prior defects

1. **Does the patient have any defects or chronic conditions?** Yes ○ No ○

If Yes, what is the origination date? dd / mm / yyyy

2. **Is there anything else you can tell us, or recommend, which would assist in our assessment, or the most effective treatment?**

Declaration

I certify that to the best of my belief the foregoing statements are correct.

Signature ..... Date dd / mm / yyyy

Printed name Qualifications

Address

SAVE AS PRINT